STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 10/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(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 A complaint investigation was conducted from 10/25/19 to 10/26/19 (Event ID # GOC411). One of the fourteen allegations was substantiated.	F 000		
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 interview, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 1 of 4 residents observed during a medication pass (Resident #9). The findings included: 1. Resident #9 was admitted to the facility on 9/18/19 with cumulative diagnoses some of which included Type 2 Diabetes Mellitus, Hypertension, and kidney transplant status. A. The October 2019 physician orders for Resident #9 included an order for the medication Cyclosporine Modified in the amount of 100 milligrams (mg) to be administered to the resident in the form of one capsule by mouth every morning at 8:00 AM. An additional physician's order for October 2019 for Resident #9 included an order for the medication Cyclosporine Modified in the amount of 75 mg to be administered to the	F 759	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #9 physician was immediately notified and orders obtained to administer three 25 mg tabs to equal 75mg of cyclosporine to receive the 100mg as ordered. This was given to Resident number 9 by nurse number 1. A medication error report was completed and the responsible party was notified. Physician was also notified of insulin being given with a meal and orders obtained to administer the residents insulin 30 minutes before a meal, during the meal, or up to 30 minutes after the meal. The Responsible party was notified of the change in insulin administration. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	11/15/19

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

Electronically Signed | 11/11/2019

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F 759	Continued From page 1 resident in the form of three capsules 25 mg each, by mouth every evening at 8:00 PM. Cyclosporine was a medication being given to the resident as an immunosuppressant to prevent rejection of a kidney transplant. Nurse #1 was observed on 10/26/19 beginning at 8:49 AM to begin to prepare medications for Resident #9 at her medication cart. Nurse #1 removed a box labeled as containing Cyclosporine Modified 25 mg capsules. The nurse ripped one of the blister packets from the card of medication. Nurse #1 was observed to get scissors, cut open the blister packet, and put one capsule into the medication cup. Nurse #1 administered all the medications prepared in a cup to Resident #9, who was able to swallow all her medication with water. Nurse #1 was interviewed at 10:20 AM on 10/26/19. Nurse #1 looked at the physician orders and opened her medication cart to look at the box of Cyclosporine Modified with 25 milligram capsules and confirmed that this was the box from which she removed the blister packet and administered the one capsule to Resident #9. Nurse #1 removed, from the medication cart, another box of Cyclosporine Modified with 100 milligrams capsules directly next to the box of Cyclosporine 25 milligram capsules. The nurse confirmed Resident #9 was supposed to receive one capsule of 100 milligram Cyclosporine Modified at 8:00 AM instead of one capsule of 25 milligram Cyclosporine Modified. The Assistant Director of Nursing (ADON) was interviewed simultaneously with Nurse #1 at 10:20 AM on 10/26/19. The ADON indicated that the medication error was made because the two	F 759	All residents have potential to be affected by a medication error. All licensed nursing staff and medication aides will be educated by the Administrator, Director of Nursing or designee on the 5 rights of medication administration (right resident, right medication, right dose, right time, right route). This will be completed by November 11th. Review of the 5 rights of medication administration will be part of orientation for all licensed nursing staff and all medication aides. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Director of Nursing, Assistant Director of Nursing Unit Coordinators will conduct medication pass observations on each shift 7a to 7p and 7p to 7a with at least two nurses twice a week for three weeks. observations of medication administration will then be conducted once a week for three weeks. Quarterly, medication administration pass will be observed by the Director of Nursing, Assistant Director of Nursing, and Unit managers randomly on each shift 7a to 7p and 7p to 7a. Any licensed nurse or medication aide found making a medication error during an observation will receive one on one education provided the Director of Nursing, Assistant Director of Nursing, and /or Unit Coordinator and then will be observed during medication pass to prove competence.	

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F 759	Continued From page 2 boxes of the same medication were side by side in the cart and Nurse #1 grabbed the wrong one. The ADON also revealed the resident's physician would be called and notified of the error. B. The October 2019 physician orders for Resident #9 included an order for the blood sugar of Resident #9 to be checked and sliding scale was to be used to administer Novolog insulin subcutaneously. Review of the medication administration record (MAR) revealed the blood sugar of Resident #9 was scheduled to be checked at 6:00 AM. An additional physician's order for Resident #9 was for the administration of 12 units of Novolog insulin mix 70-30 administered with a flex pen subcutaneously twice daily 30 minutes before a meal. Review of the MAR revealed this scheduled administration of 12 units of Novolog was to be administered at 8:00 AM. Nurse #1 was observed in the hallway to be preparing and passing out medications to residents in three other rooms on 10/26/19 between the time of 7:59 AM and 8:49 AM. Nurse #1 was observed on 10/26/19 beginning at 8:49 AM to start to prepare medications for Resident #9 at her medication cart. It was observed at 8:54 AM on 10/26/19 the breakfast tray for Resident #9 was brought into the room and placed on the bedside table. Nurse #1 was observed to be in the process of preparing medication at the medication cart outside the door of Resident #9. At 8:57 PM the nurse set up the breakfast tray for Resident #9 and the resident began eating. While Resident #9 was eating, Nurse #1 finished preparing the medications and administered them to Resident	F 759	Additionally, the consultant pharmacist will observe one licensed staff and / or medication aide during a medication pass and notify the DON and Administrator of any irregularities; if identified, immediate re-education will take place. If continued non-compliance during medication pass is observed it may result in disciplinary action up to and including termination. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and date of corrective action complete: Results of the Medication observation audits will be presented at the monthly QAPI meeting until the QAPI committee determines compliance with Medication errors less than 5%.	

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F 759	Continued From page 3	F 759		

#9. Nurse #1 explained, after she returned to the cart, that she would check the blood glucose level of Resident #9 after the resident ate breakfast because it was her experience that the resident's blood glucose level would drop extremely low if given insulin before breakfast.

The Assistant Director of Nursing (ADON) explained on 10/26/19 at 10:15 AM that Nurse #1 told her she did not give scheduled insulin to Resident #9 because the blood glucose level of the resident would drop too low prior to breakfast. After reviewing the physician's order for 15 units of Novolog insulin to be administered before the meal, the ADON acknowledged that the insulin should be administered as ordered and the physician needed to be contacted to see if the order needed to be changed.

Nurse #1 was interviewed on 10/16/19 at 10:20 AM. Nurse #1 explained that she checked the blood glucose level of Resident #9 at 8:15 AM and it was 145 mg/dl (milligrams/deciliter). The nurse indicated from previous experience with the resident, Resident #9 would "bottom out" with a blood glucose level in the 60's mg/dl if given insulin prior to breakfast. Nurse #1 further explained that the resident had varied blood sugar levels that needed to be monitored prior to the administration of insulin. The nurse revealed she routinely checked the blood glucose level of Resident #9 prior to breakfast and administered insulin when the meal tray was in front of the resident. Nurse #1 also revealed she rechecked the blood sugar of Resident #9 at 9:50 AM and it was 220 mg/dl. Nurse #1 disclosed she gave the scheduled 12 units of Novolog insulin at 9:50 AM to Resident #9 but had not given any additional insulin according to the sliding scale that morning.

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F 759	Continued From page 4 Nurse #1 divulged, "I need to call the doctor to explain what is happening so he can change the order."	F 759		