STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345501	A. BUILDING _____ B. WING _____	C 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM PARKWAY 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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/20/23 through 02/23/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SV0C11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/20/2023 through 02/23/23. Event ID# SV0C11. The following intakes were investigated NC00186132, NC00189087, NC00190191, NC00190386, NC00190534, NC00191137 and NC00198362. One of the 15 complaint allegations resulted in deficiency (F760).	F 000		
F 759 SS=E	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 observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 28 opportunities, resulting in a medication error rate of 10.7% for 1 of 3 residents (Resident #20) observed during medication pass. The findings included: 1. Resident #20 was admitted to the facility on	F 759	F759 Free from Medication Error Rates of 5 Percent or More SS=E CFR(s): 483.45(f)(1) I. Resident #20 had no negative consequences from the alleged deficient practice. It is the policy of Croasdaile Village to be free from medication rates of 5% or more. II. All residents receiving medications,	3/20/23

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

Electronically Signed | 03/10/2023

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F 759	Continued From page 1 10/22/22. Her cumulative diagnoses included Parkinson's disease and atherosclerotic heart disease (a build-up of plaque in the arteries). On 2/21/23 at 9:11 AM, Nurse #1 (an agency nurse) was observed as she prepared and administered 10 oral medications for administration to Resident #20. The medications included two - 25 milligram (mg) / 100 mg tablets of carbidopa/levodopa (an immediate release formulation of a medication indicated to treat Parkinson's disease). No carbidopa/levodopa Extended Release (ER) tablets were observed to have been pulled from the medication cart for administration to the resident. A review of Resident #20's current physician's orders revealed her medications included the following, in part: one - 25 mg carbidopa / 100 mg levodopa tablet (immediate release formulation or IR) to be given by mouth four times a day for Parkinson's disease; and two - 25 mg carbidopa / 100 mg levodopa Extended Release (ER) tablets to be given 5 times a day for Parkinson's disease. An interview was conducted with Nurse #2 (a staff nurse) on 2/21/23 at 10:01 AM. During the interview, inquiry was made with regards to the discrepancy observed between the physician's orders for carbidopa/levodopa and the medications administered to Resident #20. Nurse #2 reviewed the resident's electronic medical record (EMR) and reported Resident #20 should have received both the IR and ER formulations of carbidopa/levodopa, including one - 25 mg carbidopa / 100 mg levodopa IR tablet and two - 25 mg carbidopa / 100 mg levodopa ER tablets.	F 759	including extended-release medications, have the potential to be affected. III. Education to Health Center Licensed Nursing Staff on the Administering Medications Policy including administering medications in accordance with the order and medication guidelines was initiated on 02/23/23 by the Director of Nursing. Director of Nursing or designee will complete observations on medication administration with all Health Center Licensed Nursing Staff and all new staff will be educated and observed before they are assigned a cart. IV. Director of Nursing or designee will: Observe 5 random medication administration including weekends, dayshift and night shift for accuracy and medication errors, weekly x 4 weeks, then monthly x 3 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by the Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: March 20th, 2023.	

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F 759	Continued From page 2	F 759		

On 2/21/23 at 10:03 AM, Nurse #2 was accompanied as she approached the hall medication (med) cart where Nurse #1 was working. As an observation of the medication cards on the hall med cart was initiated, Nurse #1 stated, "I didn't see an extended release [carbidopa/levodopa formulation] in here [referring to the med cart]." The observation conducted at that time revealed both the IR and ER formulations of carbidopa/levodopa were stored on the med cart. When the medication orders for Resident #20 were discussed, Nurse #1 reported she gave Resident #20 two carbidopa/levodopa ER tablets but missed giving the IR formulation of the medication to the resident. Upon sharing the observation made during the resident's medication pass, Nurse #1 again stated she was certain she gave two ER tablets of the carbidopa/levodopa but none of the immediate release tablets to Resident #20.

An interview was conducted with the facility's Interim Director of Nursing (DON) on 2/22/23 at 2:45 AM. During the interview, the concern(s) involving med administration observations for Resident #20 were discussed. The Interim DON stated she would expect nursing staff administering medications to observe the "administration rights" (referring to the right patient, the right drug, the right dose, the right route, and the right time).

2. Resident #20 was admitted to the facility on 10/22/22. Her cumulative diagnoses included Parkinson's disease and atherosclerotic heart disease (a build-up of plaque in the arteries).

On 2/21/23 at 9:11 AM, Nurse #1 (an agency nurse) was observed as she prepared 10 oral

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medications for administration to Resident #20. The medications included one - 10 milliequivalent (mEq) Extended Release (ER) tablet of potassium chloride. Nurse #1 was observed as she placed all of the oral tablets into one of 3 small plastic pouches used for crushing medications. On 2/21/23 at 9:29 AM, the nurse was observed as she crushed 4 of the tablets together (including the ER potassium chloride tablet).

On 2/21/23 at 9:32 AM, a request was made for the nurse to stop prepping the medications for administration and to review the medication bubble pack card containing the potassium chloride ER tablets. The medication card had an auxiliary sticker placed on it by the dispensing pharmacy which indicated the medication should not be crushed or chewed. Upon review of the medication card, inquiry was made as to who the nurse could go to with questions about medication administration. Nurse #1 left the med cart to get a staff nurse. After she returned to the med cart, Nurse #2 joined her. Nurse #2 confirmed at that time the potassium chloride Extended Release tablet should not be crushed. Nurse #2 instructed Nurse #1 to re-pull the medications and to administer all of Resident #20's oral medications whole, stating the resident did not require her meds to be crushed. Nurse #1 re-pulled the medications as instructed and administered them to Resident #20 on 2/21/23 at 9:41 AM. The resident was observed to take her oral medications whole with water and without difficulty.

A review of Resident #20's current physician's orders revealed her medications included 10 mEq potassium chloride ER to be given as one tablet

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F 759	Continued From page 4	F 759		

by mouth every day for hypokalemia (low potassium level in the blood).

According to Lexi-Comp, a comprehensive electronic medication database, potassium chloride ER tablets should be swallowed whole; tablets should not be crushed, chewed, or sucked on.

An interview was conducted with the facility's Interim Director of Nursing (DON) on 2/22/23 at 2:45 AM. During the interview, the concern(s) involving the med administration observations for Resident #20 were discussed. The Interim DON stated the nursing staff should be aware of which medications could and could not be crushed when they administered meds to a resident.

3. Resident #20 was admitted to the facility on 10/22/22. Her cumulative diagnoses included Parkinson's disease and atherosclerotic heart disease (a build-up of plaque in the arteries).

On 2/21/23 at 9:11 AM, Nurse #1 (an agency nurse) was observed as she prepared 10 oral medications for administration to Resident #20. The medications included one -81 milligram (mg) Delayed Release (DR) tablet of aspirin. Nurse #1 was observed as she placed all of the oral tablets (including the DR aspirin) into one of 3 small plastic pouches used for crushing medications. On 2/21/23 at 9:29 AM, the nurse was observed as she crushed 4 of the tablets together When asked if she was planning to crush all of the tablets placed into the small plastic pouches, she stated she was and reported all medications needed to be crushed for Resident #20.

On 2/21/23 at 9:32 AM, a request was made for

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F 759	Continued From page 5	F 759		

the nurse to stop prepping the medications for administration and to review the medication bubble pack card containing the 81 mg DR aspirin tablets. The medication card had an auxiliary sticker placed on it by the dispensing pharmacy which indicated the medication should not be crushed or chewed. Upon review of the medication card, inquiry was made as to who the nurse could go to with questions about medication administration. Nurse #1 left the med cart to get a staff nurse. After she returned to the med cart, Nurse #2 joined her. Nurse #2 confirmed at that time the Delayed Release aspirin tablet should not be crushed. Nurse #2 instructed Nurse #1 to re-pull the medications and to administer all of Resident #20's oral medications whole, stating the resident did not require her meds to be crushed. Nurse #1 re-pulled the medications as instructed and administered them to Resident #20 on 2/21/23 at 9:41 AM. The resident was observed to take her oral medications whole with water and without difficulty.

A review of Resident #20's current physician's orders revealed her medications included 81 mg aspirin DR to be given as one tablet by mouth every day for coronary artery disease.

According to Lexi-Comp, a comprehensive electronic medication database, aspirin DR tablets should be swallowed whole; tablets should not be cut, crushed, or chewed.

An interview was conducted with the facility's Interim Director of Nursing (DON) on 2/22/23 at 2:45 AM. During the interview, the concern(s) involving the med administration observations for Resident #20 were discussed. The Interim DON

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F 759	Continued From page 6 stated the nursing staff should be aware of which medications could and could not be crushed when they administered meds to a resident.	F 759		
F 760 SS=E	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, Nurse Practitioner (NP) and Medical Doctor (MD) interviews and record reviews, the facility failed to administer an anticoagulant medication to a resident for a period of 10 days during his stay in the facility. This occurred for 1 of 6 residents (Resident #240) whose medications were reviewed. The findings included: Resident #240 was admitted to the hospital from 10/27/21 to 11/17/21. His Hospital Discharge Summary dated 11/17/21 reported the resident was admitted for a diagnoses which included an acute embolic cerebral vascular accident (CVA). An embolic CVA is a stroke caused by a blood clot that formed elsewhere in the body and traveled through the bloodstream to the brain. During his hospital stay, Resident #240 was also diagnosed with new onset atrial fibrillation (a type of irregular heart beat) and started on apixaban (an anticoagulant medication) to help prevent blood clots and strokes due to atrial fibrillation. A notation on the Hospital Discharge Summary read, "He should now continue apixaban for embolic CVA."	F 760	I. Resident #240 had no negative consequences from the alleged deficient practice. Resident no longer resides in the facility. II. New admits from the hospital with an anticoagulant order have the potential to be affected. Chart review of all residents currently residing in the Health Center who has an order for anticoagulant medication was done and verified by NP to ensure accuracy of orders. III. The Medical Director initiated education for all providers to ensure that new admission orders for anticoagulants with a stop date are reviewed and continued if needed by the resident. Initiated 02/23/23. Education for all licensed nurses on admission order chart review and verification with provider on anticoagulants with a stop date was initiated on 02/23/23 by the Director of Nursing. All New Hires and Agency nurses will be educated prior to their first assignment on	3/20/23

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F 760	Continued From page 7 The Hospital Discharge Medication list dated 11/17/21 included, in part, apixaban to be given as "one tablet (5 mg [milligram] total) by mouth every 12 hours for 30 days." The resident was admitted to the facility on 11/17/21. A review of Resident #240's November 2021 Physician Orders and Medication Administration Records (MAR) revealed a verbal order was received and initiated on 11/17/21 for 5 mg apixaban to be given by mouth every 12 hours for atrial fibrillation/CVA. The apixaban order included an end date of 12/18/21. A review of the resident's admission Minimum Data Set (MDS) assessment dated 11/17/21 (the date of admission) indicated Resident #240 had moderately impaired cognition and received an anticoagulant medication. A Progress Note dated 11/18/21 and authored by Resident #240's Medical Doctor (MD) at the facility reported his medication list included, in part: 5 mg apixaban twice daily. The resident's history was noted in the Progress Note and read in part, " ...He should now continue apixaban for embolic CVA." Resident #240's care plan included the following area of focus initiated on 12/12/21: Anticoagulant: "I am currently on an anticoagulant and I am at risk for abnormal bleeding." The interventions included, "Please provide me my meds as ordered" (Start Date 12/12/21). The resident's electronic medical record (EMR) revealed the facility's Nurse Practitioner (NP) saw him on 12/14/21 for follow-up. The progress note	F 760	the cart by Director of Nursing or designee. IV. Director of Nursing or designee will: Review all new admit orders with an anticoagulant and verify order for accuracy if there was a stop date, weekly x 4 weeks, then monthly x 3 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by the Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: March 20th, 2023.	

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reported Resident #240's Medication List included 5 mg apixaban to be given twice daily. A notation made under the topic of Diagnosis and Assessment read, in part: "Cerebrovascular accident (CVA) due to bilateral embolism of anterior [towards the front] cerebral arteries continue Eliquis [apixaban]..."

Resident #240's December 2021 MAR indicated the resident's last dose of apixaban was administered on 12/17/21 at 8:00 PM. Apixaban was discontinued on 12/18/21 in accordance with the stop date of the initial medication order dated 11/17/21.

Further review of Resident #240's December 2021 Physician Orders and MAR revealed a verbal order was received on 12/28/21 for 5 mg apixaban to be administered by mouth every 12 hours for history of CVA/atrial fibrillation (with no end date). This MAR indicated apixaban was re-started for Resident #240 on 12/28/21 at 8:00 PM. The MAR also documented no doses of apixaban were administered to Resident #240 from 12/18/21 through 12/27/21 (a period of 10 days).

The resident was seen by the NP on 1/3/22 due to his upcoming transfer to an Assisted Living Facility (ALF). The NP's progress note included a notation which read, " ...continue Eliquis [apixaban] and transfer to ALF..." Resident #240 was discharged from the facility on 1/7/22.

An interview was conducted on 2/22/23 at 9:40 AM with the facility's NP. During the interview, the discontinuation of Resident #240's apixaban for a period of 10 days during his stay at the facility was discussed. Upon review of the initial

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order for the apixaban (dated 11/17/21), the NP stated verbal orders were received from an on-call physician for Resident #240's admission medications. The NP reported the hospital MD should not have included an end date in the Discharge Medication List for apixaban.

An interview was conducted on 2/23/23 at 9:12 AM with the facility's Interim Director of Nursing (DON) and Administrator. During the interview, the concern regarding a lapse in the medication orders for Resident #240's apixaban was discussed. Information obtained during the NP's interview on 2/22/23 was shared. The NP reported an on-call physician had initially approved the hospital discharge medications at the time of Resident #240's admission. The order for 5 mg apixaban to be given twice a day included "times 30 days" and was apparently input into the facility's computer system with an end date for the medication as 12/18/21. When asked what their thoughts were, the DON stated the resident would have been seen by the NP or MD within the first 30 days of his stay. The NP or MD would have had an opportunity to review of the resident's medication orders at the time of these visit(s).

An interview was conducted on 2/23/23 at 11:41 AM with the resident's MD (who also served as the facility's Medical Director). The MD reported she had been made aware of the concerns expressed about a lapse in Resident #240's apixaban and had an opportunity to review his medical record prior to the interview. The MD reported she was aware the facility had previously encountered some issues with the hospital discharge med orders as a resident was transferred to the facility. She stated the issues

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F 760	Continued From page 10 were addressed in the past and most of them had been fixed. However, the MD stated, "It's up to us as the physicians to catch this. I should have looked at the H&P [History and Physical] and meds to be sure no inappropriate stop date ...There's a glitch here and it's fortunate it was caught and not a bad outcome."	F 760		