DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____ JUL 14 2011	C 06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/DURHAM	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

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F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to ensure a medication error rate of less than 5% as evidenced by 4 errors out of 43 opportunities for 3 of 5 residents observed during medication pass resulting in an error rate of 9.3% (Residents #11, #19 and #25). The findings include: 1. Resident #11 was admitted to the facility on 05/09/11 and had diagnoses including Hypertension and End Stage Renal Disease. a. A review of the physician ' s orders for June, 2011 revealed an order that read: " Metoprolol Tartrate 50mg (milligrams) tab (tablet) 1½ tablet. Give 75mg total dosage by mouth BID (twice a day). " Metoprolol is a medication used to treat hypertension. There was also an order that read: " Promethazine 25mg tablet. 1 tablet by mouth q (every) 6 hours PRN (as needed). " Promethazine is a medication used to treat nausea. On 06/28/11 at 9:30 AM, Nurse #1 was observed to prepare medications for Resident #11. The Nurse was observed to prepare rena-vite 1 tablet, norvasc 10mg 1 tablet and metoprolol 50mg 1	F 332	Resident #11 received Metoprolol 75mg at 9:30am on 6/28/11 per physician order by Nurse #1. Resident #11 was given Lisinopril 25 mg. within the scheduled time frame by Nurse #1 at 9:30am on 6/28/11 per medication record. Resident #1 had vital signs obtained on 6/29/11, 6/30/11 and 7/12/11 and remained within normal limits. Resident #19 received Advair 250/50 one dose from the discus on 6/28/11 at 9:00am. Through observation and resident statement, resident #19 takes one full inhalation two times a day, unless she occasionally refuses. Medication Administration Record was corrected to reflect the physician order of "Inhale one puff by mouth twice daily." There have been no adverse effects. Resident #25 received Atrovent, the original order by Nurse #3. Current, physician orders were reviewed by attending physician on 6/28/11. Physician order was	7/22/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donald B. Joseph | TITLE: Administrator | (X6) DATE: 7-14-11

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 332	Continued From page 1 tablet. The nurse then removed a tablet from a punch card and stated that the medication was metoprolol 25mg to equal a dose of 75mg and the nurse handed the punch card to the surveyor. Upon inspection of the punch card by the surveyor, the card read: " Promethazine 25mg. " The surveyor did not return the card to the nurse. The nurse was observed to enter the resident ' s room with the prepared medications. The nurse was asked to return to the medication cart to review the punch card for accuracy. The nurse was observed to look at the card and read out loud: " promethazine. " The Nurse was observed to remove the promethazine tablet from the cup and dispose of the medication. The nurse was then observed to correctly add metoprolol 25mg to the prepared medications. Nurse #1 stated in an interview on 06/28/11 at 9:32 AM that she misread the punch card. The Director of Nursing (DON) stated in an interview on 06/28/11 at 3:30 PM that Nurse #1 had reported the error and that the nurse stated that she thought that she had the punch card for the metoprolol 25mg. b. On 06/28/11 at 9:30 AM, Nurse #1 was observed to prepare medications for Resident #11. The Nurse was observed to prepare rena-vite 1 tablet, norvasc 10mg 1 tablet, metoprolol 50mg 1 tablet and metoprolol 25mg 1 tablet and was observed to administer the medications to the resident. A review of the physician ' s orders for June, 2011 revealed an order dated 06/25/11 that read: " D/C (discontinue) lisinopril 20 (Symbol for	F 332	obtained as "Discharge home with all meds, home health RN/SW, send RX home with pt., continue Proair 90mcg aer 2 puffs by mouth bid prn and Atrovent 17mcg aer 2 puffs by mouth bid". Resident was D/C'd home with all medications. There was continued improvement with this resident's medical status. Medication Variance Reports were initiated for Resident #11 and #19. Physician and responsible parties were notified on 6/28/11. Current, facility residents' physician orders were reviewed for previous 90 days to ensure that Therapeutic Interchange orders and other physician orders had been implemented per physician orders by Director of Nursing and Assistant Director of Nursing and Unit Manager on 6/30 and completed on 7/5. Monday-Friday new physician orders and the 24-hour report will be reviewed during morning meeting by DON/ADON to	

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F 332	Continued From page 2 change) to 25mg (milligrams) po (by mouth) QD (every day). " Lisinopril is a medication used to treat hypertension. A review of the June 2011 Medication Administration Record (MAR) for Resident #11 revealed one entry (hand written) on the first page of the MAR that read: " lisinopril 25mg po Q (every) day. " The MAR showed that the medication was to be given at 9:00 AM and the lisinopril was initialed as given on June 26th and 27th. Nurse #1 stated in an interview on 06/28/11 at 9:45 AM that she had completed the medication pass for Resident #11. When questioned about the lisinopril, Nurse #1 stated: " I missed that one. " The Nurse stated that she had looked through the MAR several times during the medication pass and did not see the lisinopril. The Director of Nursing (DON) stated in an interview on 06/28/11 at 3:30 PM that Nurse #1 reported the error to her and that the nurse stated that during the medication pass she thought that the resident was supposed to get another medication but did not see the lisinopril on the MAR. 2. Resident #19 was admitted to the facility on 05/26/11 and had diagnoses including COPD (Chronic Obstructive Pulmonary Disease). On 06/29/11 at 8:40 AM, Nurse #2 was observed to administer medications to Resident #19. Nurse #2 was observed to reach in the drawer of the medication cart and open a box and remove a container from a foil pouch without picking up the box. Nurse #2 was observed to hand the resident an Advair 250/50 Diskus. The resident took 1 puff	F 332	ensure that orders have been implemented and transcribed to the medication administration record for the next 30 days by Director of Nursing or Assistant Diretor, or Unit Manager. Nurse #1 had med pass audit completed on 7/10/11 by DON. Nurse #2 had med pass audits completed on 7/12/11, 7/13/11 by DON, SDC, Unit Mgr. Nurse #3 had med pass audit completed on 7/6/11 by DON ensuring improved performance and continued competency. Nurse #1 had formal counseling related to medication errors of above. Med pass audits for licensed nurses began on 6/27/11 and will be completed on 7/22/11. One – two random med pass audits will continue weekly x 4, bi-monthly x 1 and documented on medication administration observation form. Any facility licensed staff identified to have >5% error rate will have supervised observations until criteria is met.	

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F 332	Continued From page 3 from the inhaler and held out the inhaler to the nurse. The nurse instructed the resident to take another puff from the inhaler and the resident took a second puff from the inhaler. Advair is a medication used to treat breathing problems associated with COPD. A review of the June 2011 Medication Administration Record (MAR) for Resident #19 revealed a hand written entry that read: " Advair Inhalant Bid. " The entry did not specify the number of puffs to be administered. A review of the Physician ' s Telephone Orders revealed an order dated 06/20/11 that read: " Clarification : Advair Inhaler 250/50 diskus 1 inhalation twice daily. " In an interview with Nurse #2 on 06/29/11 at 9:00 AM the Nurse stated that the resident was supposed to receive 2 puffs of the advair and stated that the number of puffs of advair to be administered to the resident was written on the box that housed the advair diskus. The nurse was observed to remove a box of advair from the medication cart. The box was labeled with the name of resident #19 and the directions read: " Inhale 1 puff by mouth twice daily. " The nurse stated that the resident was supposed to receive only one puff of the advair inhaler. In an interview with the Director of Nursing (DON) on 06/29/11 at 10:00 AM, the DON acknowledged that this was a medication error. 3. Resident # 25 was admitted to the facility on 06/03/11 and had diagnoses including Chronic Obstructive Pulmonary Disease.	F 332	Facility licensed staff received education regarding medication management per Medication Management Tool Kit by SDC and completed by 7/22/11. Medication Management test per Medication Management Tool Kit has been given to facility licensed staff by SDC and completed by 7/22/11. Facility licensed staff was provided re-education on 7/6/11 by DON and completed on 7/22/11 by DON/ADON/SDC. Facility licensed staff was provided education regarding medication administration on 7/7/11 by Omnicare Nurse Consultant and completed on 7/22/11 by DON/ADON/SDC. Newly hired licensed employees will be provided education regarding medication management to include administration of medication.	

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F 332	Continued From page 4 On 06/29/11 at 9:22 AM, Nurse #3 was observed to prepare medications for Resident #25. The nurse was observed to look through the medication cart and stated that she was unable to find the resident ' s atrovent inhaler. The nurse stated that she would check in the medication room to see if a new one had been ordered. The nurse returned and stated that there was not one in the medication room for the resident. The nurse then stated that she checked with another nurse who told her to get an atrovent inhaler from the medication back up kit and to label the box with the resident ' s name. The nurse was observed to correctly administer the medication to the resident. The June 2011 Medication Administration Record (MAR) contained an entry that read: " Atrovent inh (inhaler)-2puffs BiD (twice a day). " The MAR was initialed indicating that the 9 PM dose was given on 06/28/11. Review of the June 2011 physician ' s orders revealed a form titled Therapeutic Interchange Request/Physician Order. The form was from the facility ' s consulting pharmacy, was dated 06/06/11 and made the following recommendation: " Discontinue the following order for (name of Resident #25). Atrovent. Inhale 2 puffs by mouth twice daily. Replace with this order: Spiriva 18 mcg (micrograms) cap. Inhale the contents of one capsule orally once daily. Start when current supply is exhausted. " The form contained a physician ' s signature and was dated 06/17/11. Below the physician ' s signature was a section that read: " Nursing Instructions: 1. The above medication order noted by: _____ Date: _____. 2.	F 332	The facility QA Pharmacy Committee (MMAC) was held on 7/12/11 and attended by the Administrator, Medical Director, Pharmacist, DON, ADON and SDC. All medication variances were reviewed at that time, including the medication incidents in question in this document. The Director of Nursing will report results of physician orders and medication observation audits to Quality Assurance Committee weekly for four weeks, bi-monthly for one month. The committee will review and analyze data for trends and further action to be taken.	

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F 332	Continued From page 5 Update the resident ' s medication administration record with order change. 3. Place order in the resident ' s clinical record. 4. Begin the new order when the current supply of medication is completed. " Number 1 of the nursing instructions was not signed or dated that the order had been noted by nursing and the order change was not written on the MAR to alert the medication nurses that the medication was to be changed when the current supply had been used. The Director of Nursing (DON) stated in an interview on 06/29/11 at 10:00 AM that the pharmacy communication form had not been signed by a nurse so she did not know who to talk with regarding the order not being carried out. The DON stated that the current supply of medication was to be completed so that the medication was not wasted. The Director of Nursing (DON) stated in an interview on 06/29/22 at 10:50 AM that the pharmacy recommendation forms were placed in the physician ' s communication book for the physician to review. The DON stated that the physician indicated their response on the form and placed the form in a box for the nurses to respond to any new orders. The DON stated that once the physician signed the form, the pharmacy recommendation became an order. The DON stated that she had spoken to medical records and discovered that medical records personnel thought that they were supposed to file the forms located in the box on the resident ' s chart and the forms had sometimes been put on the chart before the nurses had a chance to respond to the new orders.	F 332		