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

107 (75 cg)

PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-0391

| ŧ  |                                       |   | MEDIO/NO OLIVVIOLO  |                     |      |   | OMPR                   | 0.0000 000         |
|--|---------------------------------------|---|---|---------------------|------|---|------------------------|--------------------|
|  |                                       | OF DEFICIENCIES<br>CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:     | (X2) MU<br>A. BUILO |      | LE CONSTRUCTION   | (X3) DATE SU<br>COMPLE |                    |
|  |                                       |   | 0.540   | B. WING             | ;    | <del></del>   |                        | С                  |
|  | · · · · · · · · · · · · · · · · · · · |   | 345113  |                     |      |   | 10/·                   | 19/2012            |
|  | NAME OF PR                            | OVIDER OR SUPPLIER                              |   | ļ                   | STRE | EET ADDRESS, CITY, STATE, ZIP CODE  |                        |                    |
|  | WILLOW                                | CREEK NURSING AND R                             | EHABILITATION CENTER                                      | 1                   |      | 101 WAYNE MEMORIAL DRIVE  |                        |                    |
|  |                                       |   |   |                     | G    | OLDSBORO, NC 27534  |                        |                    |
|  | (X4) ID                               |   | ATEMENT OF DEFICIENCIES                                   | 10                  | .    | PROVIDER'S PLAN OF CORRECTI   |                        | (X5)<br>COMPLETION |
|  | PREFIX<br>TAG                         |   | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG       | ١    | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO              |                        | DATE               |
| e de la constante de la consta |                                       |   |   |                     |      | DEELGIENCY)   |                        |                    |
|  |                                       |   |   |                     |      | Willow Creek acknowledges receip  | nt of the              |                    |
| -  | F 000                                 | INITIAL COMMENTS                                |   | F O                 | വ    | Statement of Deficiencies and pro   |                        | 1-                 |
| ı  |                                       |   |   |                     | - 1  | Plan of Correction to the extent th   | •                      | Ì                  |
|  |                                       | The Division of Health                          | n Service Regulation                                      |                     | - 1  |   |                        | -                  |
| - 1  |                                       | (DHSR), Nursing Hom                             |   |                     | - 1  | summary of findings is factually co   |                        |                    |
| ı  |                                       | Certification Section b                         |   |                     |      | in order to maintain compliance w   |                        |                    |
|  |                                       | investigation survey of                         | •   |                     | - 1  | applicable rules and provisions of care of residents. The Plan of Corre     |                        |                    |
|  | ĺ                                     |   | complaint survey, it was                                  |                     | ì    | <del>-</del>  |                        |                    |
|  |                                       |   | had provided substandard                                  |                     | - 1  | submitted as a written allegation of  | ) !                    |                    |
| 1  |                                       |   | nmediate Jeopardy level. as conducted on 10/19/12         |                     | ŀ    | compliance.   |                        |                    |
| -  |                                       |   | e was held with the facility                              |                     |      | Willow Creek's response to this Sta   | stement                |                    |
|  |                                       |   | ediate Jeopardy began on                                  | •                   |      | of Deficiencies does not denote ag  |                        |                    |
|  |                                       | 10/01/12 and was removed on 10/19/12.           |   |                     |      | with the Statement of Deficiencies  | •                      |                    |
| -  | F 329                                 | 483.25(I) DRUG REGI                             | · · · · · · · · · · · · · · · · · · ·                     | F 3                 |      | it constitute an admission that any   |                        | 11-1-12            |
| ١  | SS=J                                  | UNNECESSARY DRU                                 |   |                     |      | -   |                        | 11-1-12            |
|  |                                       |   |   |                     |      | deficiency is accurate. Further, Wi<br>Creek reserves the right to refute a |                        |                    |
|  | -                                     |   | egimen must be free from                                  |                     |      | deficiencies on this Statement of   | any or the             | ]                  |
|  | ļ                                     |   | n unnecessary drug is any                                 |                     | - 1  |   | uto                    | 1                  |
| 1  |                                       |   | essive dose (including                                    |                     | t t  | Deficiencies through Informal Disp  |                        |                    |
|  |                                       |   | or excessive duration; or                                 |                     |      | Resolution, formal appeal procedu   | ire anu/or             |                    |
| -  |                                       | indications for its use;                        | itoring; or without adequate                              |                     | - 1  | any other Administrative or legal   |                        |                    |
|  |                                       |   | s which indicate the dose                                 |                     | İ    | proceeding  |                        | į                  |
|  |                                       | should be reduced or o                          |   |                     |      |   |                        |                    |
|  |                                       | combinations of the re-                         |   |                     | - 1  | Resident #170 no longer resides in  | the                    |                    |
|  |                                       |   |   |                     |      | Facility.   |                        | 1                  |
| 1  |                                       | Based on a compreher                            |   |                     |      |   |                        |                    |
|  |                                       |   | ist ensure that residents                                 |                     |      | All orders for Residents prescribed   |                        |                    |
|  |                                       | wno nave not used ant<br>given these drugs unle | ipsychotic drugs are not                                  |                     |      | Methotrexate were reviewed by th  |                        |                    |
|  |                                       |   | treat a specific condition                                |                     | - 1  | Director of Nursing for accuracy of   |                        |                    |
|  |                                       | as diagnosed and docu                           |   |                     |      | transcription to the Medication   |                        |                    |
| 1  |                                       | record; and residents w                         |   |                     |      | Administration Record, blocking of  | the                    |                    |
|  |                                       | drugs receive gradual o                         |   |                     |      | Medication Administration Record  |                        | ·                  |
|  |                                       | behavioral intervention                         |   |                     |      | appropriate order schedule and to   |                        |                    |
|  | ſ                                     |   | effort to discontinue these                               |                     |      | he accuracy of the next scheduled   |                        |                    |
|  |                                       | drugs.  |   |                     |      | he medication on 10/11/12. Noted  |                        |                    |
|  |                                       |   |   |                     |      | vere corrected as identified on 10/   |                        |                    |
|  |                                       |   |   |                     | 1    |   | /                      | ,                  |
| -  | DODATODICO                            | DECTORS OF PROVENTAGE                           | PPLIER REPRESENTATIVE'S SIGNATURE                         |                     |      | TITLE   | ·                      | (X6) DATE          |

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:DIU811

Facility ID: 923020

If continuation sheet Page 1 of 46



## PRINTED: 10/30/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A BUILDING B. WING \_\_\_ 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY: F 329 Residents to include those receiving F 329 Continued From page 1 Methotrexate continue to receive medications as ordered and as deemed necessary by the Resident's Physician. This REQUIREMENT is not met as evidenced Physical Assessments and Labs were Based on record review and staff interviews, the completed for All Residents receiving facility failed to ensure residents were free from Methotrexate by licensed nurses by an excessive dosage of methotrexate, an 10-13-12. Results of the assessment and anti-neoplastic agent, for 1 of 3 sampled labs were reviewed with the Resident's residents receiving methotrexate for the Physician and received follow up as treatment of rheumatoid arthritis (resident #170). The resident was sent to the emergency room for indicated. evaluation on 10/11/12. She was determined to have methotrexate toxicity and was admitted to All Medication Administration Records were the intensive care unit of the hospital. The audited by licensed Nurses to include the resident expired on 10/12/12 at 1:00AM. Supervisors with oversight by the Director of Nursing on 10/11/12 to ensure The Immediate Jeopardy began on 10/1/12 at medications that were ordered less than 10AM. The facility was informed of the Immediate Jeopardy on 10/18/12 at 5:55PM. daily were being administered and were Immediate Jeopardy was removed on 10/19/12 at blocked off appropriately indicating days of 5:59PM, after the facility provided a credible administration. Noted issues were allegation of compliance. The facility remained corrected as identified. Verification of out of compliance at a scope and severity level D corrections was completed on 10-16-12. (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) for A second Medication Administration Record the facility to complete employee training and to review was conducted by licensed nurses monitor its corrective action. on 10-12-12 to include the MDS Nurses, QI

and failure to thrive.

Findings include:

Resident #170 was admitted to the facility on

12/9/10 and readmitted on 5/14/12 with multiple

diagnoses including rheumatoid arthritis, stage 3

chronic kidney disease, thrombocytopenia (low

platelets), chronic unspecified hepatitis, anemia,

Nurse, Treatment Nurses and ADON with assistance and oversight by Director of

the Medication Administration Record to

the current Physician Orders to ensure

medications are being administered as

Nursing. This review included comparison of

ordered. This review also included ensuring

that Medications used less than daily were

|               |  | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                  |        |  | FORM  | ): 10/30/2012<br>MAPPROVED<br>): 0938-0391 |  |
|---------------|--|--|------------------|--------|--|---|--|--|
| STATEMENT     | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) M<br>A. BUI |        | LE CONSTRUCTION  | (X3) DATE SURVEY COMPLETED C 10/19/2012   |  |  |
|               |  | 345113   | B. WiN           | 1G     |  |   |  |  |
|               |  | REHABILITATION CENTER  ATEMENT OF DEFICIENCIES   | ID ID            | G<br>G | EET ADDRESS, CITY, STATE, ZIP CODE 401 WAYNE MEMORIAL DRIVE COLDSBORO, NC 27534  PROVIDER'S PLAN OF CORRECTS   | DRRECTION (X5)  |  |  |
| PREFIX<br>TAG | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREF<br>TAG      | łX     | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO   |   | COMPLETION<br>DATE                         |  |
| F 329         | dated 8/8/12 revealed The MDS revealed th symptoms of a swallor Record review of labor revealed a complete I hemoglobin (Hg) 13 g 12-15 g/dL), hematod and platelets 125 K/u (normal 150-400 K/uL metabolic panel dated urea nitrogen (BUN) (normal 6-23 mg/dL), (normal 6-23 mg/dL), (normal 0.5-1.10 mg/g glomerular filtration ra (milliliter/minute) (normal milliliter/minute) (normal filtration ra (milliliter/minute) (normal filtration ra (millililiter/minute) (normal filtration ra (millililiter/minute) (normal filtration) (millililiter/minute) (normal filtration ra (millililiter/minute) (normal filtration) (millililiter/minute) (normal filtration ra (millililiter/minute) (normal filtration | at's minimum data set (MDS) If she was cognitively intact, are resident had no signs or awing disorder.  Protory results dated 9/18/12 plood count (CBC) with a plot (GBC) wit | F                | 329    | blocked off indicating days for administration. Issues were correctional during the review by the Nurse. Corrections for audits were completed on 10-17-12.  All staff involved in the Methotree Administration in question for Resultant and in the facility Admin All results were negative. The Nurre-educated, drug tested and suspanded facility has suspended use of Medicality has suspended use of Medicality has suspended use of Medicality has facility, the Medication receive education related to Medication receive education related to Medication Pass Audit by the Phan Consultant or an Administrative Norder to verify competence. The rof certified Medication Aides will but will not be limited to:  Six Rights of Medication Administration  Importance of reading and understanding medication and orders | e licensed e kate sident 12 under istrator. rse was bended on . The lication 12. Prior on Aides Aide will ication a rmacy lurse in etraining include, |  |  |
|               | methotrexate read in p   |  |                  |        |  | :   |  |  |

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|        |                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) M<br>A. BUII  |                       | LE CONSTRUCTION  | (X3) DATE SU<br>COMPLE   |                            |
|--------|--------------------------|--|--|--------------------|-----------------------|--|--|----------------------------|
|        |                          |  | 345113   | B, WIN             | G                     |  |  | C<br>19/2012               |
|        |                          | ROVIDER OR SUPPLIER<br>CREEK NURSING AND R   | EHABILITATION CENTER   |                    | 24                    | EET ADDRESS, CITY, STATE, ZIP CODE<br>101 WAYNE MEMORIAL DRIVE<br>OLDSBORO, NC 27534   |  |                            |
| ميتداه | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |                       | PROVIDER'S PLAN OF CORRECTIV<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | D BE   | (X5)<br>COMPLETION<br>DATE |
|        |                          | reduced in patients wi Such patients require monitoring for toxicity. opportunistic infection methotrexate therapy.  Precautions - Methotre serious toxicity. Toxic frequency and severity administration but hav The clinical pharmacol not been well studied i diminished hepatic and low doses should be copatients should be clossigns of toxicity.  Geriatric use - post-masuggests that the occus suppression, thrombod may increase with age  Renal - methotrexate in that may lead to acute  Overdosage - symptom following oral overdose and signs reported at particularly hematologic reactions. For example blood cells), thrombody pancytopenia (low white cells, and platelets), bo mucositis, stomatitis, or vomiting, and gastrointer. | n the treatment of methotrexate elimination is th impaired renal function. especially careful Potentially fatal is may occur with exate has the potential for effects may be related in a to dose or frequency of e been seen at all doses. Hogy of methotrexate has in older individuals. Due to do renal function, relatively considered, and these sely monitored for early earketing experience errence of bone marrow expropenia, and pneumonitis enay cause renal damage renal failure.  The commonly reported enclation include those symptoms charmacologic doses, count gastrointestinal enclation, anemia, ele blood cells, red blood ne marrow suppression, | F                  | t<br>a<br>a<br>n<br>e | <ul> <li>Special instructions/alerts packaging and MARs to in those for medications with unusual dosing schedules that could be potentially example *****!!!!!!! or a sign.</li> <li>Infection Control measure related to the Medication Additional measure are being provided by the Dispensing Pharmacy in the distant labeling process to minimize administration error potential for medications at high risk for medicateror.</li> <li>Examples of labeling currently in usual label that reads "High Aler Double-Check" affixed to the bottle dispensed to a ror for the emergency drug A mini-monograph with congrid dispensed with bottle handout is printed on brigh pink/red paper.</li> <li>Statements added to preson labels and MAR, "Double-codose. Use calibrated syring the dispensed bottle.</li> </ul> | aclude th to or those toxic, for stop tes a Pass ided by pensing tion tee are: auxiliary t. tesident kit conversion This at cription heck tige." |                            |

|   | DEPART   | MENT OF HEALTH AN         | ID HUMAN SERVICES                                     |          |                |  |              | VI APPROVED                 |  |  |
|---|--|---------------------------|---|----------|----------------|--|--------------|-----------------------------|--|--|
|   |  |                           | MEDICAID SERVICES                                     |          |                |  |              | VI APPROVED<br>). 0938-0391 |  |  |
|   |  | OF DEFICIENCIES           | (X1) PROVIDER/SUPPLIER/CLIA                           | (X2) MU  | JLTIPL         | E CONSTRUCTION                                   | (X3) DATE SU |                             |  |  |
|   | AND PLAN OF  | CORRECTION                | IDENTIFICATION NUMBER:                                | A. BUILE |                |  | COMPLETED    |                             |  |  |
|   |  |                           |   | ļ        |                |  |              | С                           |  |  |
|   |  |                           | 345113  | B. WING  | B. WING 10/    |  |              |                             |  |  |
|   | NAME OF PR   | ROVIDER OR SUPPLIER       |   |          | STRE           | ET ADDRESS, CITY, STATE, ZIP CODE                |              |                             |  |  |
|   |  |                           |   | 1        |                | 01 WAYNE MEMORIAL DRIVE                          |              |                             |  |  |
|   | WILLOW   | CREEK NURSING AND R       | EHABILITATION CENTER                                  | [        | GC             | OLDSBORO, NC 27534                               |              |                             |  |  |
|   | (X4) ID  | SUMMARY ST                | ATEMENT OF DEFICIENCIES                               | iD       | <del>- T</del> | PROVIDER'S PLAN OF CORRECTION                    | ON           | (X5)                        |  |  |
|   | PREFIX   | (EACH DEFICIENC)          | Y MUST BE PRECEDED BY FULL                            | PREFIX   | x              | (EACH CORRECTIVE ACTION SHOUL                    | D BE         | COMPLETION                  |  |  |
|   | TAG  | REGULATORY OR I           | SC IDENTIFYING INFORMATION)                           | TAG      |                | CROSS-REFERENCED TO THE APPROI                   | PRIATE       | DATE                        |  |  |
| f |  |                           |   |          |                |  |              |                             |  |  |
|   | F 329  | Continued From none       |   |          |                | <ul> <li>5) Exclamation points placed</li> </ul> | l hefore     | ĺ                           |  |  |
| 1 | 1 323  | Continued From page       |   | F3       | 529            | the medication name on t                         |              |                             |  |  |
|   |  |                           | s such as sepsis or septic<br>nd aplastic anemia were |          |                | MAR/product label                                |              |                             |  |  |
|   |  | also reported."           | по аріазно аненна мете                                |          |                | MAIN PLOUDEL LABOR                               |              |                             |  |  |
| Į |  | aloo roportou.            |   |          |                | 6) "Tall Man" letters will be                    | used for     | -                           |  |  |
|   |  | Review of the residen     | t's September medication                              |          |                | sound alike and look alike                       | -            |                             |  |  |
|   |  | administration record     | (MAR) revealed a                                      |          |                | names on the MAR/prod                            |              |                             |  |  |
|   |  |                           | ed 9/19/12 for Methotrexate                           |          |                | (per the ISMP – institute                        | for safe     |                             |  |  |
|   |  |                           | outh every 7 days. Review                             |          |                | medication practice – รนยู                       | ggested      |                             |  |  |
| 1 |  |                           | tablets of methotrexate                               |          |                | list).   |              |                             |  |  |
| Ì |  | were given on Wedne       | •   |          |                |  |              |                             |  |  |
| ı |  | Wednesday 9/26/12 a       | t toaw.   |          |                | Beginning with the Medication de                 | livery to    |                             |  |  |
| ı |  | Review of the provide     | r pharmacy's delivery sheet                           |          | 1              | the facility on 10-17-12 the follow              | ing          |                             |  |  |
| ı |  |                           | rate 2.5mg tablets were                               |          |                | changes for dispensing Methotrex                 | ate were     |                             |  |  |
| 1 | 1  | delivered to the facility |   |          | į              | implemented:                                     |              |                             |  |  |
| 1 |  | 9/19/12.                  |   |          |                |  |              |                             |  |  |
| ı |  |                           |   |          |                | -Package all Methotrexate orders                 | in bingo     |                             |  |  |
| Į | 1  |                           | r MAR read "Methotrexate                              |          | - 1            | packaging each time the drug is di               | spensed      |                             |  |  |
|   | -  | tab 2.5mg 4=10 mg by      | mouth every / days quency!!***" There was no          |          |                | from the pharmacy                                |              |                             |  |  |
| 1 |  |                           | ing on the MAR that noted                             |          | - 1            | -Send only one week supply each                  |              |                             |  |  |
|   | ĺ  |                           | ion times. The medication                             |          | - 1            | drug is dispensed from the pharm                 | •            |                             |  |  |
|   | ļ  |                           | n Wednesday 10/3/12 and                               |          |                | In addition to cautionary wording                |              |                             |  |  |
| ı |  | Wednesday 10/10/12.       |   |          |                | DOSE AND FREQUENCY!!!*** In si                   | g            |                             |  |  |
|   | The state of the s |                           | was given at 10AM 'on                                 |          | •              | (directions), place a                            |              |                             |  |  |
| 1 |  |                           | /12, 10/4/12, 10/6/12, and                            |          |                | stop sign shaped caution auxiliary               |              |                             |  |  |
| l |  | 10/7/12, as indicated by  | •   |          | - 1            | the packaging that reads "HIGH A                 | LERT         |                             |  |  |
| I |  | and marked through w      | ntry for 10/5/12 was initialed ith an "X" with no     |          | ł              | CAUTION"   |              |                             |  |  |
| ١ |  |                           | k of the MAR. Entries for                             |          | -              | -Move Methotrexate to high risk s                | tation in    |                             |  |  |
|   |  | 10/8/12 and 10/9/12 w     |   |          | 1.             | pharmacy   | ļ            |                             |  |  |
| ı |  |                           | ck of the MAR. The entry                              | 1        | - 1            | Have Registered Pharmacist doub                  | 1            |                             |  |  |
|   |  |                           | ed and circled, indicating                            | İ        | f              | final product in addition to initial r           | eview        |                             |  |  |
|   |  | the medication was no     | t given.  |          | (              | each time the drug is dispensed fr               | om the       |                             |  |  |
| l | 1  |                           |   | 1        |                | pharmacy.  |              |                             |  |  |
| ı | 1  |                           | MAR revealed the 8PM                                  | İ        |                |  |              |                             |  |  |
|   |  | •                         | hypertensive) and Coreg                               |          |                |  |              |                             |  |  |
|   | 1 1  | COLOGRAPHICA WATER        | OESO (BL 158:0 LZ 1100/12                             | ,        | - 1            |  |              |                             |  |  |

## PRINTED: 10/30/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEEICIENCY F 329 Continued From page 5 Previous supply of Methotrexate for all Residents receiving the medication was and 10/9/12 due to low blood pressure. returned to the pharmacy on 10-17-12 Review of nursing notes dated 10/8/12 at 9:49AM upon receipt of the new supply of revealed the resident refused her scheduled Methotrexate in the new packaging. medications due to swallowing issues. Her New packaging remains in use for Lotensin and Coreg were held due to low blood Resident's receiving Methotrexate. pressure. The nurse assessed the resident and called the physician. The physician ordered In-services by the Staff Facilitator were Diflucan and Nystatin oral suspension (antifungal initiated on 10/11/12 for all licensed Nurses agents). and Medication Aides on the Six Rights of Review of nursing notes dated 10/9/12 at 7:26AM Medication Administration to include revealed the resident complained of sore mouth blocking the Medication Administration and throat. She refused all morning meds except Record for medications given less than daily one-half of a Lortab 5/500 (narcotic analgesic). by the nurse that transcribed the medication to the Medication Review of nursing notes dated 10/10/12 at Administration Record or by the nurses co-4:41PM revealed the resident was found with dried frank red blood to her lips with complaints of signing the monthly orders to aide with pain. The dried blood was cleansed away which ensuring that medications are administered revealed several open areas to the bottom lip. as ordered as a deemed necessary by the Pressure was applied to stop the bleeding and a Resident's Physician. In-servicing was lip moisturizer was applied. completed on 10-31-12 Nurses hired after 10-12-12 will be in-serviced during their Record review revealed physician orders dated orientation process by the Staff Facilitator. 10/10/12 to hold methotrexate until the resident was seen by her rheumatologist. The physician added Duragesic (narcotic analgesic) for the Additional in-servicing was initiated on resident's ulcerative stomatitis, held her 10/12/12 by the Staff Facilitator for licensed prednisone (corticosteroid) and Plaquenil (arthritis nurses and Medication Aides on signs and medication), and started ½ normal saline solution symptoms of Methotrexate Toxicity. Inintravenously (IV) at 70 ml/hr (milliliter/hour). servicing was completed on 10-31-12 Nurses hired after 10-12-12 will be in-

Record review revealed an Incident Report dated

10/11/12 at 9:30AM for resident #170. The report

read "resident has order for methotrexate 10mg every 7 days, on MAR signed for every day for 7 days. Predisposing factors - staff related. MD

the Staff Facilitator.

serviced during their orientation process by

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

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| CERTER                   | S FOR WEDICARE &              | MEDICAID SERVICES   |                   |  |   | OMD 14C                  | 7. 0000-000                |
|--------------------------|-------------------------------|---|-------------------|--|---|--------------------------|----------------------------|
|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                           | (X2) M<br>A. BUI  |  | PLE CONSTRUCTION G  | (X3) DATE SUF<br>COMPLET | ED                         |
|                          |                               | 245442  | B. WIN            | ıG   |   |                          | 0.0040                     |
|                          |                               | 345113  | <u> </u>          |  | 10/19/20  |                          |                            |
| NAME OF PE               | ROVIDER OR SUPPLIER           |   |                   | 1  | REET ADDRESS, CITY, STATE, ZIP CODE   |                          |                            |
| WILLOW                   | CREEK NURSING AND R           | REHABILITATION CENTER   |                   | 2401 WAYNE MEMORIAL DRIVE<br>GOLDSBORO, NC 27534 |   |                          |                            |
|                          |                               |   |                   |  | · · · · · · · · · · · · · · · · · · ·   |                          | 1                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | 1D<br>PREF<br>TAG |  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULO BE                   | (X5)<br>COMPLETION<br>DATE |
|                          |                               |   |                   |  |   | ·                        |                            |
| F 329                    | Continued From page           | e 6   | · F               | 329  | An Interview Tool was develope  | ed and                   |                            |
|                          | notified."                    |   |                   |  | implemented on 10-18-12 to aid  |                          |                            |
|                          |                               |   |                   |  | validating the comprehension of   | fthe                     |                            |
|                          |                               | ed physician orders dated   | ***               | •  | information provided. All nurses  |                          |                            |
|                          | -                             | nmediate) methotrexate  |                   |  | interviewed by an Administrativ   |                          |                            |
|                          |                               | anel, and renal function  |                   |  | prior to the beginning of their so  | heduled                  |                            |
|                          | ł                             | was unable to obtain an<br>ble for the labs, the physician                      | 1                 |  | shift. Interviews were complete   | d on                     |                            |
|                          |                               | ne emergency room for   |                   |  | 10-31-12 and will continue to be  |                          |                            |
|                          | evaluation.                   | io omorgano, rosm to:   |                   |  | by the Staff Facilitator or an Adr  | ninistrative             |                            |
|                          |                               |   | İ                 |  | 1 per shift for 4 weeks, then one   | daily for a              |                            |
|                          | Nursing notes dated 1         | 10/11/12 at 10:20AM   |                   |  | minimum of 4 weeks.   |                          |                            |
|                          |                               | was sent to the emergency   | -                 |  |   |                          |                            |
|                          | room with hypotension         | n and bleeding mouth sores.   |                   |  | Medication Administration audi  | ts began on              |                            |
|                          | Depart ravious of the         | hamital Emergency Doom  |                   |  | 10-12-12 for all licensed Nurses  | and were                 |                            |
|                          |                               | hospital Emergency Room<br>the resident presented with                          |                   |  | completed on 10/19/12 by a Su   | pervisor or              |                            |
|                          |                               | ed mental status. The   |                   |  | Administrative Nurse to include   | MDS                      |                            |
|                          |                               | dried blood on her lips and   | 1                 |  | Nurses, QI Nurse, and the ADON  |                          |                            |
|                          | was told she was bein         | ng treated for mouth pain.  |                   |  | medication audits consist of the  |                          |                            |
|                          |                               | icated but not clearly. The   | İ                 |  | Medication Pass Audit Form dev  |                          |                            |
|                          |                               | she seems to understand   |                   |  | the pharmacy which consists of  |                          |                            |
|                          |                               | nod her head yes or no to . When she initially arrives,                         |                   |  | of multiple medications and req   |                          |                            |
|                          |                               | to be alert certainly to her  |                   |  | than 5% error rate to pass. The   |                          |                            |
|                          |                               | ne is, i.e. the hospital."  |                   |  | includes observing to ensure the  |                          |                            |
| Ì                        | When the physician a          | · · · · · · · · · · · · · · · · · · ·   | }                 |  | medications are given as ordere   | - 1                      |                            |
|                          | resident said "my mou         | ıth hurts."   |                   |  | with the elimination of unneces   | •                        |                            |
| 1                        |                               | tion in the ER revealed   |                   |  | medications. Concerns were ad-  | 1                        |                            |
|                          | pulse of 70, respiration      |   |                   |  | the time of the observation. Nu   |                          |                            |
|                          |                               | rature 95.4, and oxygen<br>nasal cannula. A cardiac                             |                   |  | Med Pass error rate of 5% or gr   |                          |                            |
|                          |                               | ter, occult blood test, and   |                   | -  | received a second Med Pass Au   |                          |                            |
|                          |                               | were ordered. Hematology  |                   |  | Administrative Nurse. Nurses hi   | ,                        |                            |
|                          |                               | te blood count (WBC) of 2.1   |                   | 1  | 10-19-12 will receive a Med Pas   | 1                        |                            |
|                          | K/mm3 (thousand/cub           | ic millimeter) (normal 4.5 -  |                   |  | within 2 weeks of completion of   | the                      |                            |
|                          | 13.5 M/mm3), Hg 7.5           | g/dL (nomal 12-15 g/dL),  |                   | -  |   |                          |                            |
|                          |                               | mal 36-46%), and platelet   |                   | ł  |   |                          |                            |
|                          | count of 11 K/uL (norm        | nal 150-400 K/uL).  | 1                 |  |   |                          |                            |

### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING\_ 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEEICIENCY) Orientation process.-Med Pass audits will F 329 Continued From page 7 F 329 continue to be completed by an Chemistry results revealed a BUN of 120mg/dL Administrative Nurse 1 per shift for 3 days a (normal 6-23 mg/dL), creatinine 2.5 mg/dL week for 4 weeks, then 1 per shift for 2 (normal 0.5-1.10 mg/dL), and GFR of 20 ml/min (normal > 60ml/min). A stool hemoccult, a test days a week for 4 weeks then 1 per shift for for gastro-intestinal (GI) bleeding, was positive. 1 day for a minimum of 4 weeks. The resident received two units of IV fluids and Beginning 11-1-12 her blood pressure dropped. She received two units of blood and her blood pressure stabilized. She was admitted to the Intensive Care Unit for Beginning 10/12/12 Medication anemia and hypotension. The ER report read "I Administration Records to include for those think that she has a very poor prognosis and Residents receiving Methotrexate will be death would not be surprising based on the poor reviewed by an Administrative Nurse using presentation here in the Emergency Department." a current census to ensure medications Record review revealed the resident was given less than daily are blocked off on the admitted to the Intensive Care Unit (ICU) on MAR and are being administered as 10/11/12 at 5PM. Orders included laboratory ordered. This audit will be completed daily x monitoring, oxygen, chest X-ray, blood cultures, 14 days then 3 x weekly for a minimum of 6 urinalysis, IV fluids, and medications including weeks. folate, thiamine (supplements), solu-medrol (corticosteroid), Diflucan, acyclovir (anti-viral), Beginning with the November 2012, the Nexium (GI bleeding, reflux), morphine (narcotic Medication Administration Record change analgesic), and Invanz (antibiotic). Blood cultures were positive for pseudomonas aeruginosa over will incorporate a third check by two (bacterial infection). licensed Nurses to ensure accuracy of the MAR according to current Physician Orders The Summary of Hospital Course revealed and to ensure all medications given less physician notes which read in part "patient is than daily have been blocked off on the profoundly cachectic, chronically ill appearing MAR. A Resident Census will be used as the white female who presented from the nursing audit tool to show completion of the audit. home with hypotension and decreased level of Audit will be completed by the end of the consciousness with evidence of mouth pain and first day of the new MAR implementation dried blood on her lips. She complains of severe mouth pain. Shortly after arrival she became and will occur for a minimum of 3 months. progressively hypotensive and unresponsive...She was noted to be markedly

white blood cells)."

anemic, thrombocytopenic, and neutropenic (low

|                          |   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                     |     |   |  | M APPROVED<br>D. 0938-0391 |
|--------------------------|---|--|---------------------|-----|---|--|----------------------------|
| STATEMENT                | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MU<br>A. BUIL  |     | LE CONSTRUCTION   | (X3) DATE SU   | RVEY                       |
|                          |   | 345113   | B. WING             |     |   | 1  | C<br>9/2012                |
|                          | ROVIDER OR SUPPLIER  CREEK NURSING AND R  | REHABILITATION CENTER  |                     | 24  | REET ADDRESS, CITY, STATE, ZIP CODE<br>401 WAYNE MEMORIAL DRIVE<br>BOLDSBORO, NC 27534  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC (DENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | Х   | PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOU  CROSS-REFERENCED TO THE APPRO  DESIGNATION  DESIGNATION  PROVIDER'S PLAN OF CORRECT  PROVIDER'S PLAN OF CORRECT  PROVIDER'S PLAN OF CORRECT  PROVIDER'S PLAN OF CORRECT  PROVIDER'S PLAN OF CORRECT  (EACH CORRECT)  PROVIDER'S PLAN OF CORRECT  (EACH CORRECT) | LO BE  | (X6)<br>COMPLETION<br>DATE |
| F 329                    | An addendum dated medical list was revie apparently taking met as well as Plaquenil. for therapy unclear at IV folate and followup contributing to the mu pancytopenia present  The Assessment/Plant failure, hypotension/set Leukopenic. Etiologythrombocytopenia medication effectora acidosis, anemia, cacidosis, anemia, cacidosis, anemia, cacideconditioning."  The hospital Death St Cause of Death: sepsileukopenia/pancytope methotrexate." The Firsepsis syndrome sectleukopenia/immunosu methotrexate, acute reacute tubular necrosis anemia, and metabolica acute renal failure." In 10/12/12 at 1:00AM.  In an interview on 10/1 medication aide #1 stagiving oral medications MAR, check the medication against right medication and displayed as the medication and disp | no/11/12 read "patient wed and currently is thotrexate on a daily basis Not on folic acid. Indication this point. Will administer level. Certainly may be acositis and severe on admission."  In read in part "acute renal epsis - blood pressure low. of sepsis unclear at present question if related to at lesions/sores, metabolic thexia, chronic hepatitis, ammary read "Preliminary is syndrome secondary to inal Diagnoses read: condary to ppression contributed to by enal failure secondary to the resident expired on 18/12 at 3:16PM, | F                   | 329 | Results of the audits will be reviet addressed weekly as completed keeping of Nursing, Quality Improvement of the Quality Improvement Commit weekly review of identification of development of action plans and determine the need and for frequential continuing QI monitoring.  | oy the overnent is of the arded to ttee for frends, to |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| DEDAD             | TAICHT OF HEALTH A  | ID IN MAN OFFICE  |                  |         |  | PRINTI                 | ED: 10/30/201      |
|-------------------|---|---|------------------|---------|--|------------------------|--------------------|
|                   | TMENT OF HEALTH AN  |   |                  |         |  | FOF                    | RM APPROVE         |
| CENTE             | RS FOR MEDICARE &   | MEDICAID SERVICES   |                  |         |  | OMB N                  | IO. 0938-039       |
|                   | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:         | (X2) M<br>A. BUI |         | PLE CONSTRUCTION  G  | (X3) DATE SI<br>COMPLE |                    |
| 1                 |   | 1   |                  |         |  | i                      | С                  |
|                   |   | 345113  | B. WI            | NG      |  | 10/19/2012             |                    |
| NAME OF           | PROVIDER OR SUPPLIER  |   | •                | STE     | REET ADDRESS, CITY, STATE, ZIP CODE  |                        |                    |
|                   |   |   |                  | ì       | 2401 WAYNE MEMORIAL DRIVE  |                        |                    |
| WILLOW            | CREEK NURSING AND F   | REHABILITATION CENTER   |                  |         | GOLDSBORO, NC 27534  |                        |                    |
| NA ID             | CUMMADVET   | ATEMENT OF DEFICIENCIES                                       | 1                | <u></u> | PROVIDER'S PLAN OF CORREC  |                        | 1                  |
| (X4) ID<br>PREFIX |   | Y MUST BE PRECEDED BY FULL                                    | ID<br>PREF       | łΧ      | (EACH CORRECTIVE ACTION SHO  |                        | (X5)<br>COMPLETION |
| TAG               | REGULATORY OR   | LSC IDENTIFYING INFORMATION)                                  | TAG              |         | CROSS-REFERENCED TO THE APPR   | ROPRIATE               | ĐATE               |
|                   |   |   |                  |         | DEEIGIENCY)  |                        |                    |
|                   |   |   | 1                |         |  |                        |                    |
| - F 329           | Continued From page   | 9   | F                | 329     | and the second of the second o |                        |                    |
| 1                 | the MAR. If a medica  | ition was not given for any                                   |                  |         |  |                        |                    |
|                   |   | he MAR, and circled her                                       |                  |         | İ  |                        |                    |
|                   | initials. For medication  | ons ordered weekly, a   |                  |         |  |                        |                    |
|                   | square box was made around the day on the MAR that the medication was due or the days it was not given were "X'd" out. The med aide |   |                  |         |  |                        |                    |
|                   |   |   |                  |         |  |                        | }                  |
|                   |   |   |                  |         |  |                        |                    |
|                   | 1   | exate order on resident                                       |                  |         |  |                        |                    |
| ĺ                 |   | nowledged she had initialed                                   |                  |         | 10 mg mg mg mg mg mg mg mg mg mg mg mg mg  |                        |                    |
| ļ                 | it as given on 10/3/12 but stated "I don'   |   |                  |         |  |                        |                    |
|                   | remember if I gave it or not." Her initials were  |   |                  |         |  |                        |                    |
| •                 |   | dicating the medication was                                   |                  |         |  |                        |                    |
|                   |   | oticed the methotrexate was                                   |                  |         |  |                        |                    |
|                   |   | ven but every seven days                                      |                  |         |  |                        |                    |
| :                 |   | nurse. She also reported<br>int of mouth pain at that         |                  |         |  |                        |                    |
|                   | time.   | nt of mount pain at that                                      |                  | İ       |  |                        |                    |
|                   | uno.  |   |                  |         |  |                        |                    |
|                   | In an interview on 10/  | 18/12 at 3:43PM, nurse #1                                     |                  |         | :  |                        |                    |
|                   |   | or giving medication was to                                   |                  |         |  |                        |                    |
|                   | check the order on the  |   | 1                |         |  |                        |                    |
|                   | medication label versu  | is the MAR, pour and give                                     |                  | - 1     |  |                        |                    |
|                   |   | en sign the MAR. For  |                  |         |  |                        |                    |
|                   |   | eekly, the MAR was marked                                     | 1                |         |  |                        |                    |
|                   |   | he day it was due and X'd                                     |                  |         |  |                        |                    |
|                   | out the other days. The   |   |                  |         |  |                        |                    |
|                   |   | consible for marking the                                      |                  |         |  |                        |                    |
|                   | current MAR. Two nu   |   |                  |         |  |                        |                    |
|                   | 1   | efore the first of the month                                  |                  |         |  |                        |                    |
|                   |   | for marking the boxes and                                     | ļ                |         |  |                        |                    |
|                   | 1   | t given daily. Nurse #1                                       |                  |         |  |                        |                    |
|                   | reviewed the methotre   | xate order on resident<br>e acknowledged she had              | 1                | 1       |  |                        |                    |
|                   | I .   | ů .   | 1                |         |  |                        |                    |
|                   | ł   | out then crossed it out. She<br>0/8/12 and left the entry for | 1                |         |  |                        |                    |
|                   | J   | he nurse stated there was                                     | 1                |         |  |                        |                    |
| 1                 | i   |   |                  | İ       |  |                        |                    |
| •                 | no methotrexate in the cart and she did not give it. The nurse stated she should have circled her                                   |   | ļ                |         |  |                        |                    |
|                   | 1   | resean on the back of the                                     |                  |         |  |                        |                    |

|                          |  | MEDICAID SERVICES  |                   |     |   |                            | RM APPROVE(<br>NO. 0938-0391 |   |
|--------------------------|--|--|-------------------|-----|---|----------------------------|------------------------------|---|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) M            |     | TIPLE CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |                              | 1 |
|                          |  | 345113   | B. WIN            | NG. |   | 10                         | C<br>/19/2012                |   |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                   | s   | STREET ADDRESS, CITY, STATE, ZIP CODE   |                            | 11312012                     | 1 |
| WILLOW                   | CREEK NURSING AND R  | REHABILITATION CENTER  |                   |     | 2401 WAYNE MEMORIAL DRIVE   |                            |                              |   |
|                          |  |  |                   |     | GOLDSBORO, NC 27534   |                            |                              |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC<br>REGULATORY OR I   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | ΙX  | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE<br>ROPRIATE        | (X5)<br>COMPLETION<br>DATE   |   |
|                          | ordered only every see report the resident was the pharmacy. The methotrexate was given aware that it was usual. In an interview on 10/medication aide #2 start medications, she check then checked the drug label against medications not order marked with an X on the and marked with a book the nurse was responsively appropriate days on the checked the new MAR MARS and new orders the methotrexate order and acknowledged she 10/2/12, and 10/4/12. Oversight."  In an interview on 10/1 medication aide #3 state the MAR, check the doname versus the medication from the versus the MAR before medication. For medication. For medication. For medication aide reviewed on resident 170's MAR had given it on 10/6/12 | elize the methotrexate was even days. She did not as out of medication or call urse stated she knew en for arthritis but was not ally given only once weekly.  18/12 at 4:07PM, ated when she gave cked the MAR for accuracy, glabel, and then checked the MAR again. For ed daily, the MAR was he days it was not given at on the day it was given. It is is to marking the me MAR. The nurses also as twice against the old as. The med aide reviewed or on resident 170's MAR as had given it on 10/1/12, She stated "it was an as a stated "it was an administering the madministering               | 332 |   |                            |                              |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| DEPART            | MENT OF HEALTH AN                                  | ND HUMAN SERVICES                                     |  |                 |   | ,                             | D: 10/30/201<br>MAPPROVE |
|-------------------|--|---|--|-----------------|---|-------------------------------|--------------------------|
| CENTER            | RS FOR MEDICARE &                                  | MEDICAID SERVICES                                     |  |                 |   |                               | 0. 0938-039              |
| STATEMENT (       | OF DEFICIENCIES<br>F CORRECTION                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |  | ULTIPE<br>EDING | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|                   |  |   |  |                 |   | C                             |                          |
|                   |  | 345113  | B. WIN   | IG              |   | 10/1                          | 9/2012                   |
| NAME OF PE        | ROVIDER OR SUPPLIER                                |   |  | STRE            | EET ADDRESS, CITY, STATE, ZIP CODE                        | •                             |                          |
|                   |  |   |  | ł               | 01 WAYNE MEMORIAL DRIVE                                   |                               |                          |
| WILLOW (          | CREEK NURSING AND F                                | REHABILITATION CENTER                                 |  | l               | OLDSBORO, NC 27534  |                               |                          |
|                   | 1 0,000,000  | Trailer of periodicino                                |  |                 |   |                               | 1                        |
| (X4) ID<br>PREFIX | 1  | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL   | 10<br>PREF   | ıx              | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLE) |                               | (X5)<br>COMPLETION       |
| TAG               |  | LSC IDENTIFYING INFORMATION)                          | TAG  |                 | CROSS-REFERENCED TO THE APPR                              |                               | DATE                     |
|                   |  |   |  |                 | DEFICIENCY  | HENDRON SECTION               |                          |
|                   |  |   |  |                 |   |                               |                          |
| F 329             | Continued From page                                | e 11  | F  | 329             | ,   |                               |                          |
|                   |  |   |  |                 |   |                               |                          |
|                   | In a felephone intervi                             | ew on 10/18/12 at 5:15PM,                             |  |                 |   |                               |                          |
| İ                 |  | an stated the resident was                            | Ì  | ]               |   |                               |                          |
|                   |  | ologist due to her severe                             |  |                 |   |                               |                          |
|                   |  | The rheumatologist ordered                            |  |                 |   |                               |                          |
|                   |  | eekly. The physician stated                           |  |                 |   |                               |                          |
|                   |  | on the resident's lateral                             |  | 1               |   |                               |                          |
|                   | <b>!</b>   | When he assessed her two                              |  |                 |   |                               |                          |
|                   | _  | mouth was affected and he                             |  |                 |   |                               | ]                        |
|                   | sent her to the emergency room for evaluation.     |   |  | l               |   |                               |                          |
|                   | The physician stated the facility had notified him |   |  |                 |   |                               |                          |
|                   | of the medication erro                             | · · · · · · · · · · · · · · · · · · ·                 |  | 1               |   |                               |                          |
|                   |  | otrexate once weekly but he                           |  |                 |   |                               | ļ                        |
|                   |  | h she had actually received.                          |  |                 |   |                               |                          |
|                   | An interview was con-                              | ducted on 10/19/12 at                                 |  |                 |   |                               |                          |
| Ì                 | 10:11AM with one of t                              | he nurses (nurse #2)                                  |  |                 |   |                               |                          |
|                   | responsible for checking                           | ing resident 170's October                            |  |                 |   |                               |                          |
| 1                 | MAR. Nurse #2 state                                | d the new MARS came to                                |  |                 |   |                               |                          |
|                   | the facility on the 21st                           | of each month. Two                                    |  |                 |   |                               |                          |
|                   | nurses checked for ne                              | ew orders daily and added                             |  |                 |   |                               |                          |
| - 1               | them to the new MAR                                |   |  |                 |   |                               |                          |
| ſ                 | =  | last day of the month to                              |  | ]               |   |                               |                          |
| 1                 |  | had been added and the                                |  |                 |   |                               |                          |
|                   |  | For unusual dosages such                              |  |                 |   |                               |                          |
| 1                 | •  | ion, the MARS were X'd out                            |  |                 |   |                               |                          |
|                   | on the days the medic                              | ation was not to be given.                            |  |                 |   |                               |                          |
|                   |  | checked the resident's                                |  |                 |   |                               |                          |
| 1                 |  | re it was correct but did not                         |  |                 |   |                               |                          |
|                   |  | s methotrexate was not to                             |  |                 |   |                               |                          |
| 1                 | be given. She stated                               |   |  |                 |   |                               |                          |
|                   | medication was respon                              | nsible for marking the MAR.                           |  | Ì               |   |                               |                          |
|                   | In an interview on 10/2                            | 19/12 at 11:44AM nurse #3                             | and the same of th |                 |   | ,                             |                          |
|                   | In an interview on 10/19/12 at 11:44AM, nurse #3   |   | 1  |                 |   |                               |                          |
| 1                 |  |   |  |                 |   |                               |                          |
| 1                 | stated a nursing assist                            | tant had asked her to look                            |  |                 |   |                               |                          |
|                   | stated a nursing assist at resident #170 on 10     | tant had asked her to look                            |  |                 |   |                               |                          |

| DEDAGE                   | 1 4 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1  | ID THUMAN OFFICE   |                    |     |  |                                    | J: 10/30/2012              |  |
|--------------------------|--|--|--------------------|-----|--|------------------------------------|----------------------------|--|
|                          |  | ID HUMAN SERVICES MEDICAID SERVICES  |                    |     |  | FORM APPROVED<br>OMB NO. 0938-0391 |                            |  |
| STATEMENT (              | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MI            |     | LE CONSTRUCTION  | (X3) DATE SUI<br>COMPLET           | RVEY                       |  |
|                          |  | 345113   | B. WIN             | G   |  | 1                                  | C<br>9/2012                |  |
|                          | OVIDER OR SUPPLIER<br>CREEK NURSING AND R  | REHABILITATION CENTER  |                    | 24  | EET ADDRESS, CITY, STATE, ZIP CODE<br>401 WAYNE MEMORIAL DRIVE<br>GOLDSBORO, NC 27534                        |                                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | х   | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DESICIENCY) | LO BE                              | (X5)<br>COMPLETION<br>DATE |  |
|                          | methotrexate was hel started. On 10/11/12 documentation that the eating or drinking weldue to the medication resident's MAR and domethotrexate was sigweekly. The nurse chains and called the pordered stat labs and hospital. Nurse #3 staphysicians' orders we month to be sure they ordered weekly, the nurse draw a line through the line in the power of Nursing (Document of Nursing (Documen | e physician was notified, the id, and an IV fluid was in urse #3 noted he resident hadn't been it. She thought it could be is she checked the iscovered that the ned as given daily instead of necked the resident 's vital physician. The physician then sent the resident to the ated the MARS and re checked at the end of the matched. For medication urse doing the first MAR to mark the next month's he days the medication was he was supposed to X out or he other days on the MAR.  19/12 at 4:33PM, the ON) stated the staff was read the MARS and confirm on, dose, time, and route. In the month. For weekly he marked the MARS with rough the days it was not to so that checked the new he month were responsible new order was started onth, the nurse taking the for marking the MAR. The check the MAR versus the label if staff was unfamiliar with | F                  | 329 |  |                                    |                            |  |

| DEPAR                    | RTMENT OF HEALTH AN  | ID HUMAN SERVICES   |  |          |  |           | D: 10/30/2012<br>M APPROVED |  |
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|                          | ERS FOR MEDICARE & TOF DEFICIENCIES  | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA   | (X2) M   | IULTI    | IPLE CONSTRUCTION  | OMB NO    | D. 0938-0391<br>RVEY        | 1  |
|                          | OF CORRECTION  | IDENTIFICATION NUMBER:  | A. BUI   |          |  | COMPLETED |                             |  |
|                          |  | 345113  | B. WIN   | 4G _     |  | 1         | C<br>9/2012                 |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |  | ST       | REET ADDRESS, CITY, STATE, ZIP CODE  | 1 10/1    | 0,2012                      | 1  |
| WILLOW                   | V CREEK NURSING AND F  | PERABILITATION CENTER   |  | 1        | 2401 WAYNE MEMORIAL DRIVE  |           |                             | Ì  |
| WILLOW                   | · · · · · · · · · · · · · · · · · · ·  | CHADICHATION OCHTER   |  | <u> </u> | GOLDSBORO, NC 27534  |           | T                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC  |          | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRO<br>DEGICIENCY) | ILD BE    | (X5)<br>COMPLETION<br>DATE  |  |
| -                        |  |   |  |          |  |           |                             | Ī  |
| F 329                    | medication, she experinformation from one or ask other nursing some the monthly MARS to medications ordered correctly.  In a telephone interviting the physician that treastated she had multip including her age, church the physician stated contributed to the resistated adverse reaction possible at usual dose | cted them to research the of the available references, staff and/or the pharmacy. for the nurses that checked mark them to ensure that less than daily were given ew on 10/25/12 at 4:05PM, ated resident 170 in the ICU le contributing factors, ronic diseases, and debility. the methotrexate may have ident's pancytopenia. He ons to methotrexate were es and it would take days clear after it was stopped. | <b>L</b>   | 329      | 9  | •         |                             |  |
|                          | The physician stated of methotrexate the reconsidered an overdo  | he wasn't sure the amount<br>esident received would be<br>se but that it certainly  |  |          |  |           |                             |  |
|                          | Jeopardy on 10/18/12   | s notified of the Immediate<br>at 5:55PM. The facility<br>legation of compliance on<br>The allegation of  | TERRETORNIS CONTROL CO |          |  |           |                             |  |
|                          | Methotrexate 2.5mg 4 Physician. Resident 4 Methotrexate per Phy and 9/26/12 by the Methotrexate per Phy and 9/26/12 by the Methotrexate per Phy and 9/26/12 and was note of 90/50 and difficulty blood pressure medical  | # 6758 received an order for 1210mg po Q 7 days by the 16758 was administered sician's order on 9/19/12 edication Aidee. Resident by the licensed Nurse on d to have a blood pressure swallowing in which all 8pm ations were held and the rson of Resident's change  |  |          |  |           |                             | AND THE PROPERTY OF THE PROPER |

| DEBART                   | MENT OF BEALTH AN   | ID HIMAN CEDVICES   |                   |     | ·  |                                 | D: 10/30/2012              |  |
|--------------------------|---|---|-------------------|-----|--|---------------------------------|----------------------------|--|
|                          | MENT OF HEALTH AN<br>IS FOR MEDICARE & I  |   |                   |     |  | FORM APPROVED OMB NO. 0938-0391 |                            |  |
| STATEMENT (              | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) M<br>A. BUI  |     | PLE CONSTRUCTION   | (X3) DATE SU<br>COMPLE          | JRVEY                      |  |
|                          |   | 345113  | B. WIN            | G_  |  | 10/                             | C<br>19/2012               |  |
|                          | COVIDER OR SUPPLIER   | EHABILITATION CENTER  |                   | :   | REET ADDRESS, CITY, STATE, ZIP CODE<br>2401 WAYNE MEMORIAL DRIVE<br>GOLDSBORO, NC 27534                      | <u> </u>                        |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DESICIENCY) | D BE                            | (X5)<br>COMPLETION<br>DATE |  |
|                          | the MD assessed the order for Nystatin susy TID and Diflucan 100r #6758 was reassesse licensed Nurse and co and sore throat, ½ Lor by the license Nurse. 6758 lips were assess and the MD, new orde Prednisone and Plaque Methotrexate, Durage. 72 hours, and IV ½ no hour. On 10/11/12 resimouth, and mental stallicensed Nurse and the notified of Resident's corder was received to On 10/11/12 at 1023 at ER for evaluation. The informed the morning was deceased.  All staff involved were results came back neg re-educated, drug tested 10/12/12 and remains. The medication aides are nursing assistants giving All other Residents preorders were reviewed by for accuracy of transcriblocking of the MAR for | Resident and wrote an opension 5ml swish and spit and don 10/9/12 by the omplained of sore mouth that 5/500 was administered On 10/10/12 Resident # feed by the licensed Nurse are were received to hold renil, hold/stop sic 25mcg patch change Q rmal saline @ 70 cc per ident #6758 blood pressure, trus was assessed by the embland the RP was change in condition, new send to ER for evaluation. The Resident was sent to the Director of Nursing was of 10/12/12 the resident drug tested 10/12/12. All ative. The nurse was ed and suspended on suspended at this time, were re-educated. The use of medication aides, we working as certified and direct patient care.  Scribed Methotrexate initial by the Director of Nursing ption on to the MAR, revery seven day insure the accuracy of the | L.                | 329 |  |                                 |                            |  |

|   | DEPART                                    | MENT OF HEALTH AN  | ID HUMAN SERVICES  |                    |                |  |                         | M APPROVED                            |   |
|---|---|--|--|--------------------|----------------|--|-------------------------|---------------------------------------|---|
|   | CENTER                                    | S FOR MEDICARE &   | MEDICAID SERVICES  | OMB NO. 09         |                |  |                         |                                       |   |
|   |   | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                          | (X2) M<br>A. BUII  |                | PLE CONSTRUCTION   | (X3) DATE SU<br>COMPLET |                                       |   |
|   |   |  | 345113   | B. Win             |                |  | 1                       | C<br>9/2012                           |   |
|   | NAME OF PR                                | ROVIDER OR SUPPLIER  |  |                    | STI            | REET ADDRESS, CITY, STATE, ZIP CODE  |                         | 072012                                |   |
|   | WILLOW                                    | CREEK NURSING AND R  | EHABILITATION CENTER   |                    | ı              | 2401 WAYNE MEMORIAL DRIVE  |                         |                                       |   |
|   |   | OUR MADY OF  | ATEMENT OF PEROCENOIS  | 1                  | L <sup>c</sup> | GOLDSBORO, NC 27534  |                         | · · · · · · · · · · · · · · · · · · · | - |
|   | (X4) ID<br>PREFIX<br>TAG                  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID<br>PREFI<br>TAG |                | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                    | (X5)<br>COMPLETION<br>DATE            |   |
| - |   |  |  |                    |                |  |                         |                                       | Γ |
|   | F 329                                     | Continued From page  | 15   | ·F                 | 329            | t i t i t i i i i i i i i i i i i i i i  |                         |                                       |   |
|   |   | The state of the s | no doses scheduled to be   |                    |                | es estatements   |                         |                                       |   |
|   |   | . •  | e audit. Noted issues were<br>I on 10/11/12. Physical                          |                    |                |  |                         |                                       |   |
|   |   |  | mpleted on Residents on  |                    |                |  |                         |                                       |   |
|   |   | Methotrexate by licens   |  | }                  |                |  |                         |                                       |   |
|   |   | obtained by 10/12/12.  |  |                    |                |  |                         |                                       | ļ |
|   |   |  | s made by the Director of  |                    |                |  |                         |                                       |   |
|   |   | Nursing after review o   | f the medication<br>(MAR) that the orders were                                 |                    |                |  |                         |                                       |   |
|   |   |  | o the MAR. The medication  |                    |                | *****  |                         |                                       |   |
|   |   | error was the direct re  | sult of the licensed/certified   |                    |                |  |                         |                                       |   |
|   |   |  | six rights of medication<br>esident, right medication,                         |                    |                |  |                         |                                       |   |
|   |   |  | right method, right time)  |                    |                |  |                         |                                       |   |
|   |   | resulting in the medica  | ation being administered   |                    |                |  |                         |                                       |   |
|   | 1   | -  | cation administration record or medication to be given                         |                    |                |  |                         |                                       |   |
| 1 | İ   |  | a contributing factor to the   |                    |                |  |                         |                                       |   |
|   |   | medication error.  | · ·  |                    |                |  |                         |                                       |   |
|   |   | The dispensing pharm   | acy has identified the   |                    |                |  |                         |                                       |   |
|   |   | following medications  | as being at high risk for  |                    |                |  |                         |                                       |   |
|   |   | medication errors and dispensing and labelin   |  |                    |                |  |                         |                                       |   |
|   |   | administration error po  |  |                    |                |  |                         |                                       |   |
|   |   | Methotrexate- Effect   | tive 10-17-12 the following  |                    |                |  |                         |                                       |   |
|   |   | changes for dispensing   | g Methotrexate will be   |                    |                |  |                         |                                       |   |
|   |   | implemented. Beginni<br>delivery on 10-17-12:  | ng with the medication   |                    |                |  |                         |                                       |   |
|   | -Package all Methotrexate orders in bingo |  |  |                    |                |  |                         |                                       |   |
|   |   | packaging each time the pharmacy   | ne drug is dispensed from  |                    |                |  |                         |                                       |   |
|   |   | -Send only one week s  | upply each time the drug is  |                    |                |  |                         |                                       |   |
|   |   | dispensed from the pha   |  |                    |                |  |                         |                                       |   |
| - | ]   | -m addition to cautiona  | ry wording, **NOTE DOSE  |                    |                |  |                         |                                       |   |

|                          |   | ND HUMAN SERVICES MEDICAID SERVICES   |                   |                   |   | FO  | <del>ED: 10/30/201</del><br>RM APPROVEI<br>NO. 0938-039 |
|--------------------------|---|---|-------------------|-------------------|---|---|---|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ``                | (ULTIPL<br>ILDING | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED<br>C  |   |
|                          |   | 345113  | B. Wif            | 4G                |   | 10  | /19/2012  |
|                          | PROVIDER OR SUPPLIER CREEK NURSING AND  | REHABILITATION CENTER   |                   | 24                | EET ADDRESS, CITY, STATE, ZIP CODE<br>01 WAYNE MEMORIAL DRIVE<br>DLDSBORO, NC 27534 |   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC | ·IX               | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO                            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE |   |
|                          |   |   |                   |                   |   |   |   |
| F 329                    | AND FREQUENCY!!  a stop sign shaped cat packaging that reads -Move Methotrexate pharmacy -Have Registered Ph product in addition to drug is dispensed fro  2. Concentrated liquit 1) A "stop-sign sha reads "High Alert. Do bottle dispensed to a emergency drug kit 2) A mini-monograp dispensed with each printed on bright pink 3) The following sta concentrated morphic prescription label and Use calibrated syring | !*** in sig (directions), place ution auxiliary label on the "HIGH ALERT CAUTION" to high risk station in  armacist double check final initial review each time the m the pharmacy.  d morphine and oxycodone: ped" red auxiliary label that suble-Check" affixed to each resident or for the  oh with conversion grid bottle. This handout is /red paper. stement is added to each ne and oxycodone I MAR, "Double-check dose. | F.                | 329               |   |   |   |
|                          | 3. For Warfarin products exclamation points are placed before the medication name on the MAR/product label  4. "Tall Man" letters are used for sound alike and look alike drug names on the MAR/product label (per the ISMP - institute for safe medication practice - suggested list).   |   |                   |                   |   |   |   |
|                          | receive the medicatio<br>pharmacy upon receip   | Residents continuing to n have been returned to the of the 10-17-12 delivery. exate doses occurred by 2   |                   |                   |   |   |   |

| CENTER                   | RS FOR MEDICARE &   | MEDICAID SERVICES  |                       |  | OMB N                        | 1O. 0938-039               |
|--------------------------|---|--|-----------------------|--|------------------------------|----------------------------|
|                          | MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345113   |  | (X2) MUL<br>A. BUILDI | TIPLE CONSTRUCTION ING   | (X3) DATE S<br>COMPLI        |                            |
|                          |   | 345113   | B. WING               |  | 10                           | C<br>/19/2012              |
|                          | ROVIDER OR SUPPLIER CREEK NURSING AND F   | REHABILITATION CENTER  | s                     | TREET ADDRESS, CITY, STATE, ZIP CODE<br>2401 WAYNE MEMORIAL DRIVE<br>GOLDSBORO, NC 27534 |                              |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY   | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 329                    | licensed Nurses prior packaging was availa Residents receiving Nurses prior yearly dose with a sectific Resident' Medical packaging arrived in the Medications in the old returned to the pharm.  As a precautionary magacility temporarily sus Medication Aides pen administration retraining audit by the Pharmacy Administrative Nurse, medication aidees will limited to:  - the six rights of magacine the importance of medication labels and he being aware of spackaging and MARs medications with unustations that could be possible.  All Medication Administrative Nurse or a stop siguinfection control.  All Medication Administrative Nursing on 10/11/12 to were ordered less that the MAR and are being Noted issues were converification of correction 10-16-12. | to Administration until new ble. Signage to alert staff of Methotrexate and the need to cond Nurse was inserted in ation Record. The new the facility on 10/17/12. It packaging have been tacy.  Leasure on 10/12/12 the spended the use of ding medication pass by Consultant or an an amount of the retraining of certified and include, but will not be needication administration for reading and understanding orders on to include those for sould do sing schedules or stentially toxic, for example in.  Letration Records were carses to include the sight by the Director of the ensure medications that in daily were blocked off on gadministered as ordered. Trected as identified. | F 32                  |  |                              |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/30/2012

FORM APPROVED

|     |                          |   | ID HUMAN SERVICES   |                   |     |  | FOR                    | D: 10/30/2012<br>M APPROVED |
|-----|--------------------------|---|---|-------------------|-----|--|------------------------|-----------------------------|
|     | STATEMENT (              | S FOR MEDICARE & DF DEFICIENCIES CORRECTION   | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) M<br>A. BUI  |     | PLE CONSTRUCTION   | (X3) DATE SU<br>COMPLE | red                         |
|     |                          |   | 345113  | B. WIN            | 1G_ |  | ì                      | C<br>19/2012                |
|     |                          | ROVIDER OR SUPPLIER<br>CREEK NURSING AND R  | EHABILITATION CENTER  |                   | ] 2 | REET ADDRESS, CITY, STATE, ZIP CODE<br>2401 WAYNE MEMORIAL DRIVE<br>GOLDSBORO, NC 27534                    |                        |                             |
| خط: | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>FAG |     | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOWN<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLÐ BE                 | (X5)<br>COMPLETION<br>DATE  |
|     |                          | administration, blocking given less than daily in the telephone order to co-signing the month and RP of significant will be in-serviced pricinclude staff on vacation weekends by an Administration include staff on vacation weekends by an Administration, Blocking in their shift, to include staff on the interest of the | Ilicensed Nurses and the six rights of medication and the MAR for medications by the nurse that takes off the MAR or by the nurses of the MAR or by the nurses of or the MAR or by the nurses of orders, notification of MD change in condition. Staff for to beginning their shift, to on and those that only work inistrative Nurse.  I on 10/12/12 by Staff Inurses and Medication amptoms of Methotrexate in-serviced prior to beginning that on vacation and those has.  12-12 will be in-serviced in process by the Staff are Six Rights of Medications Notification of MD and RP in condition and the Signs thotrexate toxicity.  In 10/12/12 by the Staff fied Nursing Assistants on anditions that need to be Staff will be in-serviced or shift, to include staff on at only work weekends. | · F               | 329 |  |                        |                             |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 329 Continued From page 19 F 329 An Interview Tool has been developed related to in-servicing material covered with Nurses and Medication Aides related to the Six Rights of Medication Administration, Blocking the MAR for Medications given less than daily, Notification of MD and RP of significant change in condition and the Signs and Symptoms of Methotrexate toxicity. Implementation of the interview tool will occur on 10-18-12. All nurses will be interviewed by an Administrative Nurse prior to the beginning of their scheduled shift. The Staff Facilitator or Administrative nurse will use the interview tool on one nurse per shift for 4 weeks, then one nurse daily for 4 weeks. Results of interviews will be reviewed weekly by the Quality Improvement Committee. On 10/12/12 a review of all current MARS was initiated by licensed nurses to include MDS Nurses, QI Nurse, Treatment Nurses and ADON with assistance and oversight by Director of Nursing to include comparison of October MAR to the September MAR and telephone orders to ensure medications are being administered as ordered. Medication used less than daily were reviewed to ensure the MAR was blocked off. Issues were corrected as identified during the review by the licensed Nurse. Corrections were completed on 10-17-12. Beginning 10/12/12 the licensed Nurses reviewed nurse notes on all Residents from 9/11/12 to 10/12/12 ensure there are no acute issues that have not been addressed. A general assessment was completed on each Resident by a licensed

Nurse to ensure Residents did not have a change in condition that warranted the notification of the

| STATEMENT OF DEFOCISICIES AND FLORING CORRECTION DENTIFICATION NUMBER:  346113  AND DING  A BURDING  C 10/19/2012  ***STREET ADDRESS, CITY, STATE, ZIP CODE 240 WAYNE MEMORIAL DRIVE GOLDSON, N. C. 27534  (X4) ID MIRETER MEMORIAL DRIVE GOLDSON, N. C. 27534  (X4) ID MIRETER MEMORIAL DRIVE GOLDSON, N. C. 27534  (X4) ID MIRETER MEMORIAL DRIVE GOLDSON, N. C. 27534  F 329  Continued From page 20  MD and/or RP. Identified issues were addressed as indicated by the licensed Nurse.  On 10/19/12 Medication Administration audits evere started for all licensed Nurses and were completed by 10/10/12. The medication audits consist of the use of a Medication Pass Audit Form developed by the pharmacy which consists of observation of multiple medications and requiring a less than 15% error rate to pass.  Concorns were addressed by the suddling Nurse at the time of the observation. Nurses with a Med Pass error rate of 5% or greater received a second Med Pass Audit by an Administrative Nurse at the time of the observation. Nurses with a Med Pass audit will be completed by an Administrative Nurse.  Beginning 10/12/12, all telephone orders will be reviewed by the Administrative Nurse to ensure accurate transcription and blocking of the MARS for medications given less than daily on the medication solven less than daily on the medication solven less than daily on the medication of the Marks of medication of the MARS for medications given less than daily on the medication solven less than daily on the medication and the nas determined necessary by the QI team.  Beginning 10/12/12 MARS will be reviewed by the Administrative Nurse using a current consus to ensure medication record wails at 34 days, 3 x workly 6 weeks and then as determined necessary by the QI team.   | CENTER | IS FOR MEDICARE &  | MEDICAID SERVICES   |          |   |                           | OMB N | O. 0938-0391 |
|--|--------|--|---|----------|---|---------------------------|-------|--------------|
| NAME OF PROVIDER OR SUPPLIER  WILLOW CREEK NURSING AND REHABILITATION CENTER  WILLOW CREEK NURSING AND REHABILITATION CENTER  WILLOW CREEK NURSING AND REHABILITATION CENTER  SUBJECT OF THE PROVIDER OF THE PROPERTY OF THE PROPERTY OF THE PROVIDER OF THE PROVIDER OF THE PROPERTY OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROPERTY OF THE PROPERTY OF THE PROVIDER OF THE PROPERTY OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROPERTY OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROPERTY OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROPERTY OF THE P |        | (,   |   | ' '      |   |                           |       |              |
| WILLOW CREEK NURSING AND REHABILITATION CENTER    SUMMARY STATEMENT OF DETICENCIES   10   (EACH DETICINGNY MIST BE REDECIBLY MYTHE RECORD AND CONSECUTION (EACH DETICINGNY MIST BE RECEIBLY MYTHE RECORD AND CONSECUTION (EACH DETICINGNY MIST BE RECEIBLY MYTHING INFORMATION)   PIPIER (EACH DOINECTION MIST MIST RECORD AND COMPLETION MIST MIST RECORD AND COMPLETION MIST MIST RECORD AND COMPLETION MIST MIST MIST MIST MIST MIST MIST MIST  |        |  | 345113  |          |   |                           | 10/   | _            |
| FREEN TAGE CHANGE OF MUST BE PRECEDED BY PULL PLAY TAGE CHOST-RETERRICE OF THE APPROPRIATE DEFIGENCY.  F 329  Continued From page 20 MD and/or RP. Identified issues were addressed as indicated by the licensed Nurse.  On 10/12/12 Medication Administration audits were started for all iconsect Nurses and were completed by 10/19/12. The medication audits consist of the use of a Medication Pass Audit Form developed by the pharmacy which consists of observation of mutiliple medications and requiring a less than 5% error rate to pass.  Concerns were addressed by the auditing Nurse at the time of the observation. Nurses with a Med Pass error rate of 5% or greater received a second Med Pass Audit within 2 weeks of completion of the Orientation process. The Med Pass audit within 2 weeks of completion of the Orientation process. The Med Pass audit will be completed by an Administrative Nurse.  Beginning 10/12/12, all telephone orders will be reviewed by the Administrative Nurse to ensure accurate transcription and blocking of the MARS for medications given less than daily on the medication administration record using copies of the telephone orders daily x 14 days, 3 x weekly x 6 weeks and then as determined necessary by the QI team.  Beginning 10/12/12 MARS will be reviewed by the Administrative Nurse using a current consus to ensure medications that were given less than daily are blocked off on the MAR and are being administered as ordered daily x 14 days, 3 x weekly 6 weeks and then as determined   |        |  | EHABILITATION CENTER  | <u> </u> | :   | 2401 WAYNE MEMORIAL DRIVE | 1 10  | 10,2012      |
| MD and/or RP. Identified issues were addressed as indicated by the licensed Nurse.  On 10/12/12 Medication Administration audits were started for all licensed Nurses and were completed by 10/19/12. The medication audits consist of the use of a Medication Pass Audit Form developed by the pharmacy which consists of observation of multiple medications and requiring a less than 5% error rate to pass.  Concerns were addressed by the auditing Nurse at the time of the observation. Nurses with a Med Pass error rate of 5% or greater received a second Med Pass Audit by an Administrative Nurse. Nurses hired after 10-19-12 will receive a Med Pass audit within 2 weeks of completion of the Orientation process. The Med Pass audit will be completed by an Administrative Nurse.  Beginning 10/12/12, all telephone orders will be reviewed by the Administrative Nurse to ensure accurate transcription and blocking of the MARS for medications given less than daily on the medication administration record using copies of the telephone orders daily x 14 days, 3 x weekly x 6 weeks and then as determined necessary by the QI team.  Beginning 10/12/12 MARS will be reviewed by the Administrative Nurse using a current census to ensure medications that ware given less than daily are blocked off on the MAR and are being administered as ordered daily x 14 days, 3 x weekly 6 weeks and then as determined   | PREFIX | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL  | PREF     | PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR |                           |       | COMPLETION   |
| Beginning 10/12/12 the MARS of residents taking Methotrexate will be reviewed by the   |        | MD and/or RP. Idential as indicated by the lice. On 10/12/12 Medication were started for all lice completed by 10/19/1 consist of the use of a Form developed by the of observation of multirequiring a less than 5 Concerns were address at the time of the observation of Med Pass error rate of 5% second Med Pass Audit within the Orientation process be completed by an Address audit within the Orientation process be completed by an Address audit within the Orientation process be completed by an Address audit variety are viewed by the Admir accurate transcription for medications given a medication administration the telephone orders of 6 weeks and then as of the QI team.  Beginning 10/12/12 Med Administrative Nurse under the Medications the daily are blocked off or administered as orders weekly 6 weeks and the necessary by the QI team. | fied issues were addressed ensed Nurse.  on Administration audits ensed Nurses and were 2. The medication audits Medication Pass Audit e pharmacy which consists iple medications and 1% error rate to pass. Seed by the auditing Nurse envation. Nurses with a Med or greater received a lit by an Administrative fler 10-19-12 will receive a 2 weeks of completion of s. The Med Pass audit will deministrative Nurse.  If telephone orders will be nistrative Nurse to ensure and blocking of the MARS less than daily on the lion record using copies of laily x 14 days, 3 x weekly x retermined necessary by  ARS will be reviewed by the sing a current census to at ware given less than and the MAR and are being ad daily x 14 days, 3 x en as determined am | F        | 329   |                           |       |              |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/30/2012

FORM APPROVED

# PRINTED: 10/30/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 8. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 Continued From page 21 F 329 Administrative Nurses using a current census to ensure accurate administration of the medication daily x 14 days, 3 x weekly x 6 weeks and then as determined necessary by the QI team. Beginning with the November MAR, the MAR change over will incorporate a third check by two licensed Nurses on the first day of the month to ensure accuracy of the November MAR and to ensure all medications given less than daily have been blocked off on the MAR. MARs will continue to be signed off by two Nurses, the first Nurse will do the initial check when MARs arrive and the second check will be on the last day of the month prior to change over. Two licensed Nurses will audit 100% of MARs monthly x 3 months by performing a check of the hard copy MAR from the previous month and comparing it to the hard copy MAR for the current month and also incorporating the telephone orders in the third check. The two Nurses completing the third check will sign off on each hard copy and use a current census as the audit tool to show completion of the audit. Audit will be completed by the end of the first day of the new month. Results of the audit will be reviewed and addressed weekly by the Director of Nursing or the designee. The results will be compiled and forwarded to the Quality Improvement Committee for weekly review of identification of trends, development of action plans and to determine the need and for frequency of continuing QI

monitorina.

On 10/19/12 at 5:59PM, the credible allegation of compliance was validated by observations, interviews, and record review. The facility

PRINTED: 10/30/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 329 Continued From page 22 F 329 provided evidence of in-service training for all nursing staff and medication aides. In-services included medication administration, special precautions, dosage, packaging, MAR blocking, and side effects/toxicity of methotrexate. Audit tools and forms were reviewed. Record review ofother sampled residents receiving methotrexate revealed the medication was given according to the physician 's orders. MARS were appropriately blocked off to ensure once weekly dosing. Observation revealed methotrexate orders were packaged in bingo cards with only a one week supply dispensed from the pharmacy. Cautionary labels and the MARS read \*\*NOTE DOSE AND FREQUENCY!!! Other high risk medications were also labeled with cautionary labels. Interviews with all nursing staff on duty were conducted and revealed competency regarding medication administration, special precautions, dosage, packaging, MAR blocking, and side effects/toxicity of methotrexate. Interviews revealed the medication aides were no longer administering medications. Interviews revealed in-services and audits had been completed and were ongoing. Interview with the Regional Clinical Pharmacist revealed dispensing, packaging, and labeling changes for methotrexate and other high risk medications had been implemented. Medication pass observations had been completed and were ongoing. Interviews with the Administrator, DON, and administrative staff revealed monitoring tools were in place and education of the staff was ongoing. The interviews revealed active and ongoing monitoring of policy implementation.

F 333

SS=J

483,25(m)(2) RESIDENTS FREE OF

SIGNIFICANT MED ERRORS

Facility.

F 333 Resident #170 no longer resides in the

11-1-12

| DEPART                   | MENT OF HEALTH AN  | ID HUMAN SERVICES   |                   |        |  |                                   | : 10/30/2012<br>APPROVED     |
|--------------------------|--|---|-------------------|--------|--|-----------------------------------|------------------------------|
|                          |  | MEDICAID SERVICES   |                   |        |  |                                   | . 0938-0391                  |
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                   | IULTIP |  | (X3) DATE SUR<br>COMPLETE         | VEY<br>D                     |
|                          |  | 345113  | B. WIN            | 1G     |  | 10/19                             | )<br>)/2012                  |
| NAME OF D                | ROVIDER OR SUPPLIER  |   | . l               | Ι      |  | 10/10                             | //LUIL                       |
| NAME OF FI               | ROVIDER OR SUPPLIER  |   |                   | }      | EET ADDRESS, CITY, STATE, ZIP CODE<br>401 WAYNE MEMORIAL DRIVE   |                                   |                              |
| WILLOW                   | CREEK NURSING AND R  | EHABILITATION CENTER  |                   |        | OLDSBORO, NC 27534   |                                   |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |        | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | D BE<br>PRIATE                    | (X5)<br>COMPLETION<br>DATE   |
|                          |  |   |                   |        |  |                                   | Control Construction Control |
| F 333                    | Continued From page<br>The facility must ensu<br>any significant medica  | re that residents are free of   | - F               | 333    | All orders for Residents prescribed<br>Methotrexate were reviewed by the<br>Director of Nursing for accuracy of<br>transcription to the Medication   | ne                                |                              |
|                          | This REQUIREMENT is not met as evidenced by:  Based on record review, staff interviews, and physician interview, the facility failed to prevent a significant medication error for 1 of 3 sampled residents receiving methotrexate, an anti-neoplastic agent, for the treatment of rheumatoid arthritis (resident #170). The resident was given methotrexate daily instead of weekly as ordered. The resident was sent to the emergency room for evaluation on 10/11/12. She was determined to have methotrexate toxicity and  |   |                   |        | Administration Record, blocking of Medication Administration Record appropriate order schedule and to the accuracy of the next scheduled the medication on 10/11/12. Note  | to reflect<br>ensure<br>I dose of |                              |
|                          |  |   |                   |        | were corrected as identified on 10, Residents to include those receivin Methotrexate continue to receive medications as ordered and as deen necessary by the Resident's Physic in the prevention of significant me | g<br>emed<br>ian alding           |                              |
|                          | was admitted to the ir   | tensive care unit of the texpired on 10/12/12 at  |                   |        | errors.  Physical Assessments and Labs were completed for All Residents receiving  |                                   |                              |
|                          | 10AM. The facility work immediate Jeopardy of Immediate Jeopardy vortices 5:59PM, after the facility after the facility after the facility after the facility after the facility after the facility after the facility after the facility after the facility after the facility after the facility after the facility after the facility with th | on 10/18/12 at 5:55PM.<br>was removed on 10/19/12 at<br>ity provided a credible<br>ce. The facility remained                  |                   |        | Methotrexate by licensed nurses be 10-13-12. Results of the assessment labs were reviewed with the Reside Physician and received follow up a indicated.  | nt and<br>ent's                   |                              |
|                          | (no actual harm with t<br>minimal harm that is r   | scope and severity level D<br>he potential for more than<br>ot immediate jeopardy) for<br>employee training and to<br>action. |                   |        | All Medication Administration Reco<br>audited by licensed Nurses to inclu<br>Supervisors with oversight by the I<br>of Nursing on 10/11/12 to ensure   | ide the<br>Director               |                              |
|                          | Findings include:  | d Madigation  |                   |        | medications that were ordered less<br>daily were being administered and<br>blocked off appropriately indicating  | were                              |                              |
|                          | The facility policy, title<br>Administration, undate<br>deviation from the follo   |   |                   |        | administration. Noted issues were corrected as identified. Verification  | Ì                                 |                              |

considered a medication error:

corrections was completed on 10-16-12.

#### PRINTED: 10/30/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 333 Continued From page 24 F 333 A second Medication Administration Record review was conducted on 10-12-12 by To the right resident Administration of the right medication licensed nurses to include the MDS Nurses. 3. In the right dose QI Nurse, Treatment Nurses and ADON with 4. By the right route assistance and oversight by Director of 5. By the right method Nursing. This review included comparison of 6. At the right time." the Medication Administration Record to the current Physician Orders to ensure Resident #170 was admitted to the facility on medications are being administered as 12/9/10 and readmitted on 5/14/12 with multiple ordered. This review also included ensuring diagnoses including rheumatoid arthritis, stage 3 chronic kidney disease, thrombocytopenia (low that Medications used less than daily were platelets), chronic unspecified hepatitis, anemia, blocked off indicating days for and failure to thrive. administration to aide with the prevention of medication errors. Issues were corrected Review of the resident's minimum data set (MDS) as identified during the review by the dated 8/8/12 revealed she was cognitively intact. licensed Nurse. Corrections for audits were The MDS revealed the resident had no signs or completed on 10-17-12. symptoms of a swallowing disorder. Record review of laboratory results dated 9/18/12 All staff involved in the Methotrexate revealed a complete blood count (CBC) with Administration in question for Resident hemoglobin (Hg) 13 g/dl (grams/deciliter) (normal #170 were drug tested on 10/12/12 under 12-15 g/dL), hematocrit 38.7% (normal 36-46%), the direction of the facility Administrator. and platelets 125 K/uL (thousand/microliter) All results were negative. The Nurse was (normal 150-400 K/uL). Results of a basic re-educated, drug tested and suspended on metabolic panel dated 9/18/12 revealed blood 10/12/12 and remains suspended. The urea nitrogen (BUN) 92 mg/dL (milligram/deciliter) facility suspended use of Medication Aides (normal 6-23 mg/dL), creatinine 2.43 mg/dL (normal 0.5-1.10 mg/dL), and estimated indefinitely effective 10-12-12. Prior to glomerular filtration rate (GFR) of 19 ml/min reimplementation of Medication Aides use (milliliter/minute) (normal > 60 ml/min). BUN, in the facility, the Medication Aide will creatinine, and GFR are indicators of renal receive education related to Medication function.

Record review of the rheumatologist's progress notes dated 9/18/12 revealed a diagnosis of erosive rheumatoid arthritis. Recommendations included "add methotrexate 4 tabs once a week -

Administration to include having a

|           | TMENT OF HEALTH AN                              |   |                    |                      |  | FOR   | D: 10/30/201:<br>M APPROVE |
|-----------|---|---|--------------------|----------------------|--|---|----------------------------|
| STATEMENT | RS FOR MEDICARE & OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) M             |                      | CONSTRUCTION   | (X3) DATE SUI<br>COMPLET  | ED                         |
|           |   | 345113  | B. WIN             | G                    | - 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10  |   | C<br>9/2012                |
|           | SUMMARY STA<br>(EACH DEFICIENC)                 | EHABILITATION CENTER  TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG | 240<br>GO<br>X       | ET ADDRESS, CITY, STATE, ZIP CODE  1 WAYNE MEMORIAL DRIVE  LDSBORO, NC 27534  PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHOI  CROSS-REFERENCED TO THE APPR  | JLD BE  | (X5)<br>COMPLETION<br>DATE |
|           |   |   |                    |                      | DEEICIENCY)  |   |                            |
| F 333     |   |   |                    |                      | Medication Pass Audit by the Phonsultant or an Administrative order to verify competence. The of certified Medication Aides will not be limited to:  Six Rights of Medication Administration Importance of reading understanding medicate and orders  Special instructions/ale packaging and MARs to those for medications will unusual dosing schedul that could be potentiall example ****!!!!!!! or sign.  Infection Control meas related to the Medications. | Nurse in retraining linclude, in and ion labels rts on include with es or those by toxic, for a stop ures |                            |
|           |   |   | •                  | th<br>ar<br>ar<br>er | dditional measure are being prone Dispensing Pharmacy in the cond labeling process to minimize dministration error potential for nedications at high risk for medications at high risk for medications.  | dispensing<br>r<br>cation<br>use are:   |                            |
|           |   |   |                    |                      | A "stop-sign shaped" red     label that reads "High Al     Double-Check" affixed t     the bottle dispensed to a     or for the emergency dri  | ert.<br>o<br>a resident   |                            |

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

PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-0391

|   |  | EMENT OF DEFICIENCIFS (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   |                    | ULTII<br>LOIN | PLE CONSTRUCTION<br>G  | (X3) DATE SURVEY<br>COMPLETED  |                            |
|---|--|--|---|--------------------|---------------|--|--|----------------------------|
|   |  |  |   | B. WIN             | G             | -  |  | С                          |
|   |  |  | 345113  |                    | <br>          |  | 10/1   | 9/2012                     |
|   | NAME OF PE   | ROVIDER OR SUPPLIER  |   | ,                  | STI           | REET ADDRESS, CITY, STATE, ZIP CODE  |  |                            |
|   | WILLOW   | CREEK NURSING AND R  | EHABILITATION CENTER  |                    | 1             | 2401 WAYNE MEMORIAL DRIVE  |  | ,                          |
|   |  |  |   |                    |               | GOLDSBORO, NC 27534  |  | T                          |
|   | (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |               | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO-<br>DEFICIENCY).   | D BE   | (X5)<br>COMPLETION<br>DATE |
|   |  |  |   |                    |               |  |  |                            |
| CONTRACTOR OF THE PROPERTY OF | F 333  | that may lead to acute Overdosage - sympton following oral overdos and signs reported at particularly hematolog reactions. For example blood cells), thromboc pancytopenia (low whit cells, and platelets), be mucositis, stomatitis, or vomiting, and gastroin have been reports of continuous transported."  Review of the resident administration record (handwritten entry date 2.5mg 4 tablets by more and signs and so reported. | may cause renal damage renal failure.  ms commonly reported e include those symptoms pharmacologic doses, ic and gastrointestinal le, leucopenia (low white sytopenia, anemia, ite blood cells, red blood one marrow suppression, oral ulceration, nausea, testinal bleeding. There leath following overdose. It is such as sepsis or septic and aplastic anemia were | F                  | 3333          | grid dispensed with bottle handout is printed on brig pink/red paper.  3) Statements added to pres labels and MAR, "Doubledose. Use calibrated syring the dispensed bottle.  5) Exclamation points placed the medication name on the MAR/product label  6) "Tall Man" letters will be sound alike and look alike names on the MAR/product (per the ISMP – institute for medication practice – suglist).  Beginning with the Medication delithe facility on 10-17-12 the following sink in pink with the medication brighted the facility on 10-17-12 the following pink is pink with the medication brighted the facility on 10-17-12 the following pink is pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility on 10-17-12 the following pink with the medication brighted the facility with the medication brighted the facility with the medication brighted the facility with the medication brighted the facility with the medication brighted the facility with the medication brighte | e. This cht cription check nge." inge with before he used for drug act label or safe gested ivery to |                            |
|   |  | were given on Wednes<br>Wednesday 9/26/12 at   | sday 9/19/12 and  |                    |               | changes for dispensing Methotrexa<br>implemented:  | ate were   |                            |
|   |  | •  | pharmacy's delivery sheet<br>ate 2.5mg tablets were<br>for resident #170 on   |                    |               | -Package all Methotrexate orders i<br>packaging each time the drug is dis<br>from the pharmacy<br>-Send only one week supply each t  | pensed<br>ime the  |                            |
|   | The state of the s | tab 2.5mg 4=10 mg by<br>***Note Dose and Freq<br>blocking or other marki<br>the weekly administrati  | nuency!!***" There was no ng on the MAR that noted on times. The medication Wednesday 10/3/12 and   |                    |               | drug is dispensed from the pharma-in addition to cautionary wording, DOSE AND FREQUENCY!!!*** in sig (directions), place a stop sign shaped caution auxiliary the packaging that reads "HIGH ALCAUTION"  | **NOTE<br>!<br>! <u>abel</u> on  |                            |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING С B, WING\_ 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEELCIENCY) F 333 - Move Methotrexate to high risk station in Continued From page 27 pharmacy revealed methotrexate was given at 10AM 'on -Have Registered Pharmacist double check 10/1/12, 10/2/12, 10/3/12, 10/4/12, 10/6/12, and 10/7/12, as indicated by the med aides' and final product in addition to initial review nurse's initials. The entry for 10/5/12 was initialed each time the drug is dispensed from the and marked through with an "X" with no pharmacy. explanation on the back of the MAR. Entries for 10/8/12 and 10/9/12 were blank with no Previous supply of Methotrexate for all explanations on the back of the MAR. The entry Residents receiving the medication was for 10/10/12 was initialed and circled, indicating returned to the pharmacy on 10-17-12 the medication was not given. upon receipt of the new supply of Review of the October MAR revealed the 8PM Methotrexate in the new packaging. doses of Lotensin (antihypertensive) and Coreg New packaging remains in use for (anti-arrhythmic) were held on 10/5/12, 10/8/12, Resident's receiving Methotrexate. and 10/9/12 due to low blood pressure. In-services by the Staff Facilitator were initiated on 10/11/12 for all licensed Nurses Review of nursing notes dated 10/8/12 at 9:49AM and Medication Aides on the Six Rights of revealed the resident refused her scheduled Medication Administration to include medications due to swallowing issues. Her blocking the Medication Administration Lotensin and Coreg were held due to low blood Record for medications given less than daily pressure. The nurse assessed the resident and called the physician. The physician ordered by the nurse that transcribed the Diflucan and Nystatin oral suspension (antifungal medication to the Medication agents). Administration Record or by the nurses cosigning the monthly orders to aide with Review of nursing notes dated 10/9/12 at 7:26AM ensuring that medications are administered revealed the resident complained of sore mouth as ordered as a deemed necessary by the and throat. She refused all morning meds except Resident's Physician. In-servicing was one-half of a Lortab 5/500 (narcotic analgesic). completed on 10-31-12 Nurses hired after Review of nursing notes dated 10/10/12 at 10-12-12 will be in-serviced during their 4:41PM revealed the resident was found with orientation process by the Staff Facilitator. dried frank red blood to her lips with complaints of pain. The dried blood was cleansed away which revealed several open areas to the bottom lip.

lip moisturizer was applied.

Pressure was applied to stop the bleeding and a

|                          | MENT OF HEALTH AN  |  |                        |     |   | FORM           | D: 10/30/2012<br>MAPPROVED<br>D: 0938-0391 |
|--------------------------|--|--|------------------------|-----|---|----------------|--|
| STATEMENT                | RS FOR MEDICARE & OF DEFICIENCIES F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                   | (X2) MU                |     | PLE CONSTRUCTION  | (X3) DATE SUF  | RVEY                                       |
|                          |  |  |                        |     | <del></del>   |                | C  |
|                          |  | 345113   | B. WING                | ·   |   | 10/1           | 9/2012                                     |
| NAME OF PF               | ROVIDER OR SUPPLIER  |  |                        | STR | REET ADDRESS, CITY, STATE, ZIP CODE   |                |  |
| WILLOW                   | CREEK NURSING AND R  | EHABILITATION CENTER   | 1                      | 24  | 401 WAYNE MEMORIAL DRIVE  |                |  |
| III.E.C.                 | One Extra remains a remains  |  | GOLDSBORO, NC 27534    |     |   |                |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG    | (   | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPRIOR OF THE | LD BE          | (X5)<br>COMPLETION<br>DATE                 |
| ,                        |  |  | 1                      |     |   |                |  |
| F 333                    | Continued From page  | 28   | - F3                   | 33  | Additional in-servicing was initiate  | ed on          |  |
|                          | 1  | ed physician orders dated  |                        | •   | 10/12/12 by the Staff Facilitator f   | or licensed    |  |
|                          | 1  | otrexate until the resident  |                        |     | nurses and Medication Aides on s  | igns and       |  |
|                          |  | matologist. The physician  |                        |     | symptoms of Methotrexate Toxic  | ity. In-       |  |
|                          | added Duragesic (narcotic analgesic) for the   |  |                        |     | servicing was completed on 10-31  | l- <b>12</b> . |  |
| :                        | resident's ulcerative stomatitis, held her   |  |                        |     | Nurses hired after 10-12-12 will b  |                |  |
|                          | prednisone (corticosteroid) and Plaquenil (arthritis medication), and started ½ normal saline solution |  |                        |     | serviced during their orientation   | process by     |  |
|                          |  | 0 ml/hr (milliliter/hour).   | the Staff Facilitator. |     |   |                |  |
|                          | Record review reveals  | ed an Incident Report dated  |                        |     | An Interview Tool was developed   | and            |  |
|                          |  | r resident #170. The report  |                        |     | implemented on 10-18-12 to aide   | with           |  |
|                          |  | er for methotrexate 10mg   |                        |     | validating the comprehension of   | he             |  |
|                          |  | signed for every day for 7   |                        |     | information provided. All nurses v  | vere           |  |
|                          |  | ctors - staff related. MD  |                        | Ĭ   | interviewed by an Administrative  |                |  |
|                          | notified."   |  |                        |     | prior to the beginning of their sch   |                |  |
|                          | Record review reveale  | ed physician orders dated  |                        |     | shift. Interviews were completed  |                |  |
|                          |  | mediate) methotrexate  |                        |     | 10-31-12 and will continue to be  | -              |  |
|                          |  | nel, and renal function  |                        |     | by the Staff Facilitator or an Adm  |                |  |
|                          |  | was unable to obtain an  |                        |     | Nurse 1 per shift for 4 weeks, the  | n one daily    |  |
|                          | sent the resident to the   | e for the labs, the physician  |                        | -   | for a minimum of 4 weeks.   |                |  |
|                          | evaluation.  | s emergency room for   |                        | 1   | Medication Administration audits  | hogan on       |  |
|                          |  |  |                        | - 1 | 10-12-12 for all licensed Nurses a  | ~              |  |
|                          | Nursing notes dated 1  |  | 1                      | , , | completed on 10/19/12 by a Supe   |                |  |
|                          |  | was sent to the emergency  |                        |     | Administrative Nurse to include N   |                |  |
|                          | room with hypotension  | and bleeding mouth sores.  |                        | - 1 | Nurses, QI Nurse, and the ADON.   |                |  |
|                          | Record review of the h   | ospital Emergency Room   |                        | - 1 | medication audits consist of the u  |                |  |
|                          |  | he resident presented with   |                        | - 1 | Medication Pass Audit Form deve   |                |  |
|                          | hypotension and altere   |  |                        |     | the pharmacy which consists of o  |                |  |
|                          |  | dried blood on her lips and  |                        |     | of multiple medications and requi   |                |  |
|                          |  | g treated for mouth pain.  |                        |     | than 5% error rate to pass. The au  |                | ,  |
| 1                        |  | cated but not clearly. The he seems to understand                                    |                        |     | includes observing to ensure the  |                |  |
|                          | , ,  | ne seems to understand<br>nod her head ves or no to                                  |                        | - 1 | medications are given as ordered  | and if         | -  |

my questions and will nod her head yes or no to

as mentioned, seems to be alert certainly to her

appropriate questions. When she initially arrives,

medications errors are occurring. Concerns

were addressed at the time of the

### PRINTED: 10/30/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY). F 333 Continued From page 29 F 333 observation. Nurses with a Med Pass error rate of 5% or greater received a second name and to where she is, i.e. the hospital." When the physician asked if she hurt, the Med Pass Audit by an Administrative Nurse. resident said "my mouth hurts." Nurses hired after 10-19-12 will receive a Med Pass audit within 2 weeks of The physical examination in the ER revealed completion of the Orientation process. Med pulse of 70, respirations 16, blood pressure Pass audits will continue to be completed initially 110/41, temperature 95.4, and oxygen by an Administrative Nurse 1 per shift for 3 saturation of 90% on nasal cannula. A cardiac days a week for 4 weeks, then 1 per shift for monitor, urinary catheter, occult blood test, and 2 days a week for 4 weeks then 1 per shift laboratory monitoring were ordered. Hematology results revealed a white blood count (WBC) of 2.1 for 1 day for a minimum of 4 weeks. K/mm3 (thousand/cubic millimeter) (normal 4.5 -Beginning 1.1-1-12 13.5 M/mm3), Hg 7.5 g/dL (normal 12-15 g/dL), hematocrit 22.8% (normal 36-46%), and platelet Beginning 10/12/12 Medication count of 11 K/uL (normal 150-400 K/uL). Administration Records to include for those Chemistry results revealed a BUN of 120mg/dL Residents receiving Methotrexate will be (normal 6-23 mg/dL), creatinine 2.5 mg/dL reviewed by an Administrative Nurse using (normal 0.5-1.10 mg/dL), and GFR of 20 ml/min (normal > 60 ml/min). A stool hemoccult, a test a current census to ensure medications for gastro-intestinal (GI) bleeding, was positive. given less than daily are blocked off on the The resident received two units of IV fluids and MAR and are being administered as ordered her blood pressure dropped. She received two and that significant medication errors are units of blood and her blood pressure stabilized. not occurring. Any concerns identified will She was admitted to the Intensive Care Unit for be corrected at the time of discovery. This anemia and hypotension. The ER report read "I audit will be completed daily x 14 days then think that she has a very poor prognosis and 3 x weekly for a minimum of 6 weeks. death would not be surprising based on the poor presentation here in the Emergency Department." Beginning with the November 2012, the Record review revealed the resident was Medication Administration Record change admitted to the Intensive Care Unit on 10/11/12 at over will incorporate a third check by two 5PM. Orders included laboratory monitoring,

oxygen, chest X-ray, blood cultures, urinalysis, IV

fluids, and medications including folate, thiamine

(supplements), solu-medrol (corticosteroid),

and Invanz (antibiotic). Blood cultures were

Diflucan, acyclovir (anti-viral), Nexium (Gl bleeding, reflux), morphine (narcotic analgesic).

licensed Nurses to ensure accuracy of the

MAR according to current Physician Orders

MAR, A Resident Census will be used as the

audit tool to show completion of the audit.

and to ensure all medications given less

than daily have been blocked off on the

| DEPART                   | MENT OF HEALTH AN   | ID HUMAN SERVICES   |                       |  |   | <u>:D: 10/30/20</u><br>:M APPROVE |
|--------------------------|---|---|-----------------------|--|---|-----------------------------------|
| STATEMENT O              | S FOR MEDICARE &<br>F DEFICIENCIES<br>CORRECTION  | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MUL<br>A. BUILDI | TIPLE CONSTRUCTION NG  | (X3) DATE SU<br>COMPLE  |                                   |
|                          |   | 345113  | B. WING               |  | 10/   | C<br>19/2012                      |
|                          | OVIDER OR SUPPLIER  | EHABILITATION CENTER  | s                     | TREET ADDRESS, CITY, STATE, ZIP CODE<br>2401 WAYNE MEMORIAL DRIVE<br>GOLDSBORO, NC 27634   |   |                                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  |   | (X5)<br>COMPLETIO<br>DATE         |
|                          | Infection).  The Summary of Hosp physician notes which profoundly cachectic, white female who preshome with hypotensio consciousness with exdred blood on her lips mouth pain. Shortly a progressively hypoten unresponsiveShe wanemic, thrombocytop white blood cells)."  An addendum dated 1 medical list was review apparently taking methas well as Plaquenil. If for therapy unclear at its for therapy unclear at its for therapy unclear at its for the Assessment/Plan failure, hypotension/secukopenic (low white sepsis unclear at presequestion if related to mesions/sores, metabol cachexia, chronic hepatine. | pital Course revealed read in part "patient is chronically ill appearing sented from the nursing n and decreased level of vidence of mouth pain and so She complains of severe fter arrival she became sive and as noted to be markedly senic, and neutropenic (low 0/11/12 read "patient ved and currently is notrexate on a daily basis Not on folic acid. Indication this point. Will administer level. Certainly may be cositis and severe on admission."  read in part "acute renal psis - blood pressure low. blood cells). Etiology of entthrombocytopenia - sedication effectoral ic acidosis, anemia, stitis, deconditioning." | · F 33                | Audit will be completed by first day of the new MAR im and will occur for a minimular Results of the audits will be addressed weekly as compledirector of Nursing, Quality Nurse or the designee. The audits will be compiled and the Quality Improvement Coweekly review of identificat development of action plan determine the need and /or continuing QI monitoring. | reviewed and eted by the Improvement results of the forwarded to ommittee for ion of trends, s and to |                                   |

"sepsis syndrome secondary to

|                          |   | ND HUMAN SERVICES MEDICAID SERVICES   |                                       |     |  | FORM APPROVED<br>OMB NO. 0938-0391 |                            |  |
|--------------------------|---|---|---------------------------------------|-----|--|------------------------------------|----------------------------|--|
| STATEMENT                | NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | (X2) M<br>A. BUI                      |     | LTIPLE CONSTRUCTION DING   | (X3) DATE SU<br>COMPLE             | TED                        |  |
|                          |   | 345113  | B. WI                                 | NG. |  | 10/                                | C<br>19/2012               |  |
|                          | ROVIDER OR SUPPLIER   | REHABILITATION CENTER   | · · · · · · · · · · · · · · · · · · · | s   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2401 WAYNE MEMORIAL DRIVE<br>GOLDSBORO, NC 27534                |                                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC                     | ΞIX | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY). | ULD BE<br>ROPRIATE                 | (X5)<br>COMPLETION<br>DATE |  |
|                          | leukopenia/immunosomethotrexate, acute racute tubular necrosisanemia, and metabol acute renal failure." Tol/12/12 at 1:00AM.  In an interview on 10/medication aide #1 st giving oral medication MAR, check the medication agains right medication agains right medication was given the MAR. If a medicate reason, she initialed t initials. For medicatios quare box was made MAR that the medication was not given were "Vreviewed the method to given on 10/3/12 remember if I gave it circled on 10/10/12 in not given. She had not supposed to be gi and reported it to the resident's complaintime.  In an interview on 10/stated the procedure of the check the order on the medication label verse the medication, and the | repression contributed to by renal failure secondary to s, thrombocytopenia, ic acidosis secondary to The resident expired on  (18/12 at 3:16PM, ated the procedure for as was to first check the ication in the cart, remove the cart, then double check at the MAR to be sure the dose were given. After the a, she initialed the entry on ation was not given for any the MAR, and circled her are around the day on the tion was due or the days it ('d'' out. The med aide exate order on resident anowledged she had initialed but stated "I don't or not." Her initials were dicating the medication was ven but every seven days nurse. She also reported at 18/12 at 3:43PM, nurse #1 for giving medication was to | F                                     | 33  | 33   |                                    |                            |  |

|   |                          |   | ID HUMAN SERVICES  |                   |     |  |                        | M APPROVED                 |               |
|---|--------------------------|---|--|-------------------|-----|--|------------------------|----------------------------|---------------|
|   | CENTER                   | CENTERS FOR MEDICARE & MEDICAID SERVICES  TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |                   |     |  | T                      | O. 0938-0391               | 7             |
|   | 1                        |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                | (X2) N<br>A. BU   |     | TIPLE CONSTRUCTION  NG   | (X3) DATE SU<br>COMPLE |                            |               |
|   |                          |   | 345113   | B. WI             | NG_ |  | 10/                    | C<br>19/2012               |               |
|   | NAME OF PE               | ROVIDER OR SUPPLIER   |  |                   | s   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                        |                            |               |
|   | WILLOW                   | CREEK NURSING AND R   | EHABILITATION CENTER   |                   |     | 2401 WAYNE MEMORIAL DRIVE  |                        |                            |               |
|   |                          | T   |  | <del> </del>      |     | GOLDSBORO, NC 27534  |                        |                            | -             |
|   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAC | ΙX  | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FROM THE APPR | LD BE                  | (X5)<br>COMPLETION<br>DATE |               |
|   |                          |   |  |                   |     | DEFICIENCY)  |                        |                            |               |
|   | F 333                    | , ,   |  | ·F                | 33  | 13   |                        |                            | 1 2111313 4,3 |
|   |                          | out the other days. The   | the day it was due and X'd<br>he nurse that took the                                 |                   |     |  |                        |                            |               |
|   | :                        |   | ponsible for marking the   |                   |     |  |                        |                            | <u> </u>      |
|   |                          |   | irses checked the new  |                   |     |  |                        |                            |               |
|   |                          |   | efore the first of the month<br>for marking the boxes and                            |                   |     |  |                        |                            |               |
|   |                          |   | ot given daily. Nurse #1   |                   |     |  |                        |                            |               |
|   |                          |   | exate order on resident  |                   |     |  |                        |                            |               |
|   |                          |   | e acknowledged she had   |                   |     |  |                        |                            |               |
|   |                          |   | out then crossed it out. She   |                   |     |  |                        |                            | }             |
|   |                          |   | 0/8/12 and left the entry for<br>The nurse stated there was                          |                   |     |  |                        |                            |               |
|   |                          |   | e cart and she did not give  |                   |     |  |                        |                            |               |
|   |                          |   | he should have circled her   |                   |     |  |                        |                            |               |
|   |                          | initials and indicated a  | reason on the back of the  | j                 |     |  |                        |                            |               |
|   |                          |   | lize the methotrexate was  |                   |     |  |                        |                            |               |
|   |                          |   | ven days. She did not  |                   |     |  |                        |                            |               |
|   |                          | the pharmacy. The nu  | s out of medication or call use stated she knew                                      |                   |     |  |                        |                            |               |
|   |                          |   | en for arthritis but was not   | -                 |     |  |                        |                            |               |
|   |                          |   | ally given only once weekly.   |                   |     |  |                        |                            |               |
|   |                          | In an interview on 10/1   | 18/12 at 4:07PM  |                   |     |  |                        |                            |               |
|   |                          | medication aide #2 sta  |  |                   |     |  |                        |                            |               |
|   |                          |   | ked the MAR for accuracy,  |                   |     |  |                        |                            |               |
|   |                          |   | label, and then checked  |                   |     |  |                        |                            |               |
|   |                          | the drug label against  | <del>-</del>   |                   |     |  |                        |                            |               |
|   |                          | medications not ordere  | ed dally, the MAR was<br>he days it was not given                                    |                   |     |  |                        |                            |               |
| ļ |                          |   | on the day it was given.   |                   |     |  |                        |                            |               |
|   |                          | The nurse was respon  |  | 1                 |     |  |                        |                            |               |
| İ |                          | appropriate days on th  | e MAR. The nurses also   |                   |     |  |                        |                            |               |
| l |                          |   | S twice against the old  | 1                 |     |  |                        |                            |               |
| ļ |                          |   | s. The med aide reviewed   |                   |     |  |                        |                            |               |
|   |                          |   | r on resident 170's MAR  |                   |     |  |                        |                            |               |
| - | 1                        | 10/2/12, and 10/4/12.   | e had given it on 10/1/12,<br>She stated "it was an                                  |                   |     |  |                        |                            |               |
|   | İ                        | oversight."   | one stated it trad all   |                   |     |  |                        |                            |               |
|   |                          |   |  |                   |     |  |                        |                            |               |

|   |  | MENT OF HEALTH AN<br>S FOR MEDICARE & I            |  |                   |       |  | FORM          | M APPROVED<br>0. 0938-0391 |   |
|---|--|--|--|-------------------|-------|--|---------------|----------------------------|---|
|   |  | OF DEFICIENCIES                                    | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) M            | ULTIF | PLE CONSTRUCTION   | (X3) DATE SUF |                            | 1 |
|   | AND PLAN OF  | CORRECTION   | IDENTIFICATION NUMBER:   | A. BUI            | LDING | 3  | COMPLET       | ED                         |   |
|   |  |  | 345113   | B. WIN            | G     | ····   |               | C<br>9/2012                |   |
|   | NAME OF PR   | OVIDER OR SUPPLIER                                 |  |                   | STR   | REET ADDRESS, CITY, STATE, ZIP CODE  |               |                            |   |
|   | WILLOW   | CREEK NURSING AND R                                | EHABILITATION CENTER   |                   | ı     | 401 WAYNE MEMORIAL DRIVE   |               |                            |   |
|   |  |  |  |                   |       | GOLDSBORO, NC 27634  |               |                            |   |
|   | (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)                                   | NTEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CORRECTI  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY) | .D BE         | (X5)<br>COMPLETION<br>DATE |   |
|   | <del>25 50</del> 22  |  |  |                   |       |  |               |                            |   |
|   | F 333  | Continued From page                                | 33   | ; F               | 333   | ss ss comments of the same   |               |                            |   |
|   |  |  | 40/40 4-000M   |                   |       |  |               |                            |   |
|   |  | In an interview on 10/<br>medication aide #3 sta   | 18/12 at 4:29PM,<br>ated she was trained to read                                 |                   |       |  |               |                            |   |
|   |  | the MAR, check the de                              | 1  |                   |       |  |               |                            |   |
|   |  |  | ication label. She removed   |                   |       |  |               | :                          |   |
| ĺ |  |  | ne cart and checked it again   |                   |       |  |               |                            |   |
|   |  | versus the MAR befor                               | e aurninistering the cation not ordered daily, the                               |                   |       |  |               |                            |   |
|   |  |  | 'd out on the days it was not  |                   |       |  |               |                            |   |
|   |  |  | rked the X's on the MARS   |                   |       |  |               |                            |   |
|   |  |  | n monthly for accuracy.  |                   |       |  |               |                            |   |
|   |  |  | d the methotrexate order   |                   |       |  |               |                            | ŀ |
|   |  |  | R and acknowledged she<br>2 and 10/7/12. The med                                 |                   |       |  |               |                            |   |
|   |  |  | eation why she gave it daily.  |                   |       |  |               |                            |   |
|   |  | In a telephone intervie                            | w on 10/18/12 at 5:15PM,   |                   |       |  |               |                            |   |
| ı |  |  | n stated the resident was  |                   |       |  |               |                            |   |
|   |  |  | ologist due to her severe  |                   |       |  | j             |                            |   |
|   |  |  | he rheumatologist ordered ekly. The physician stated                             |                   |       |  |               |                            | l |
| - | 1  |  | on the resident's lateral  |                   |       |  |               |                            |   |
|   | Ī  |  | hen he assessed her two  |                   |       |  |               |                            |   |
|   |  | •  | mouth was affected and he  |                   |       |  |               |                            |   |
| İ |  |  | ency room for evaluation.  |                   |       |  |               |                            | ĺ |
| ļ | - Anna Caraca Caraca Caraca Caraca Caraca Caraca Caraca Caraca Caraca Caraca Caraca Caraca Caraca Caraca Carac | The physician stated to<br>of the medication error | he facility had notified him   |                   |       |  |               |                            |   |
| 1 |  |  | otrexate once weekly but he  |                   |       |  | -             |                            |   |
|   |  |  | she had actually received.   |                   |       |  |               |                            |   |
| Ĭ |  | An interview was cond                              | ucted on 10/19/12 at   |                   |       |  |               |                            |   |
|   |  | 10:11AM with one of the                            | ne nurses (nurse #2)   |                   |       |  |               |                            |   |
|   |  |  | ng resident 170's October  |                   |       |  |               |                            |   |
|   | 3  |  | I the new MARS came to   |                   |       |  |               |                            |   |
| I |  | the facility on the 21st                           |  |                   | ]     |  | ]             |                            |   |
|   |  | them to the new MARS                               | w orders daily and added S. The MARS were  |                   |       |  |               |                            |   |
|   |  |  | ast day of the month to  |                   |       |  |               |                            |   |

|            |   | AND HOWAN SERVICES  & MEDICAID SERVICES                  |        |  |  |          | RM APPROVE<br>10. 0938-039 |  |
|------------|---|--|--------|--|--|----------|----------------------------|--|
| STATEMENT  | ERS FOR MEDICARE & MEDICAID SERVICES IT OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |        | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |          | (X3) DATE SURVEY COMPLETED |  |
| [          |   |  | A. BU  | (LDII                                  | 4G   |          | С                          |  |
|            |   | 345113   | B. WIN | NG_                                    |  | 10       | /19/2012                   |  |
| NAME OF PE | ROVIDER OR SUPPLIER   |  | t      | - C-                                   | TREET ADDRESS, CITY, STATE, ZIP CODE   |          | 7 (0)20 (2                 |  |
|            | 10 1,021,1 07,1 001,1 2,12,1  |  |        | "                                      | 2401 WAYNE MEMORIAL DRIVE  |          |                            |  |
| WILLOW     | CREEK NURSING AND   | REHABILITATION CENTER                                    |        |  | GOLDSBORO, NC 27534  |          |                            |  |
| (X4) ID    | SUMMARY   | STATEMENT OF DEFICIENCIES                                | ID     | 1                                      | PROVIDER'S PLAN OF CORREC  | CTION    | (X5)                       |  |
| PREFIX     | (EACH DEFICIE   | NCY MUST BE PRECEDED BY FULL                             | PREF   | IX                                     | (EACH CORRECTIVE ACTION SHO  | ,        |                            |  |
| TAG        | L   | R LSC IDENTIFYING INFORMATION)                           | TAG    | 3<br>                                  | CROSS-REFERENCED TO THE APPI<br>DEFICIENCY)  | ROPRIATE | DATE                       |  |
|            |   |  |        |  |  |          |                            |  |
| F 333      | Continued From pa   | ae 34  | ·F     | 333                                    | 3 77 224 247   |          |                            |  |
|            | ,   | ers had been added and the                               | '      | 00.                                    | 1  |          | 1                          |  |
|            |   | rs had been added and the<br>i. For unusual dosages such |        |  |  |          |                            |  |
|            |   | ration, the MARS were X' out                             |        |  |  |          |                            |  |
|            |   | dication was not to be given.                            |        |  |  |          |                            |  |
|            | ,   | ne checked the resident's                                |        |  |  |          |                            |  |
|            |   | sure it was correct but did not                          |        |  |  |          |                            |  |
|            |   | ays methotrexate was not to                              |        |  |  |          | -                          |  |
|            |   | ed the nurse giving the                                  |        |  |  |          |                            |  |
|            |   | o me nurse giving me ponsible for marking the MAR.       |        |  |  |          |                            |  |
|            | meulealion was 185  | ponsible for marking the IVIAN.                          |        |  |  |          |                            |  |
|            | In an intensiow on 1  | 0/19/12 at 11:44AM, nurse #3                             |        |  |  |          |                            |  |
|            |   | sistant had asked her to look                            |        |  |  |          |                            |  |
|            |   | 10/10/12. The resident                                   |        |  |  |          |                            |  |
|            |   | h pain and had blood on her                              |        |  | a. A service of the s |          |                            |  |
|            |   | e applied a cool washcloth to                            |        |  |  |          |                            |  |
|            |   | he physician was notified, the                           |        |  |  |          |                            |  |
|            |   | eld, and an IV fluid was                                 | ļ      |  |  |          |                            |  |
|            | started. On 10/11/1   |  |        |  |  |          |                            |  |
|            |   | the resident hadn't been                                 |        |  |  |          |                            |  |
|            |   | ell. She thought it could be                             |        |  |  |          |                            |  |
|            |   | on. She checked the                                      |        |  |  |          |                            |  |
|            | resident's MAR and  |  |        |  |  |          |                            |  |
|            |   | igned as given daily instead of                          |        |  |  |          |                            |  |
|            |   | checked the resident 's vital                            |        |  |  |          |                            |  |
|            |   | physician. The physician                                 |        |  |  |          |                            |  |
|            | •   | d then sent the resident to the                          |        |  |  |          |                            |  |
|            |   | stated the MARS and                                      |        |  | -  |          |                            |  |
|            | •   | ere checked at the end of the                            |        |  |  |          |                            |  |
|            | • •   | ey matched. For medication                               |        |  |  |          |                            |  |
|            |   | nurse doing the first MAR                                |        |  |  |          |                            |  |
|            |   | d to mark the next month's                               |        |  |  |          |                            |  |
| 1          |   | he days the medication was                               |        |  |  |          |                            |  |
|            |   | rse was supposed to X out or                             | -      |  |  |          |                            |  |
|            |   | the other days on the MAR.                               |        |  |  |          |                            |  |
|            | la an intenderus es 40  | 140442 of 4-22DM 45-                                     |        |  |  |          |                            |  |
| ĺ          |   |  |        |  |  |          |                            |  |
|            |   |  |        |  |  |          |                            |  |
|            | In an interview on 10<br>Director of Nursing (  | 0/19/12 at 4:33PM, the DON) stated the staff was         |        |  |  |          |                            |  |

|     | DEPART        | MENT OF HEALTH AN         | ID HUMAN SERVICES  |              |       |   | FOR          | M APPROVED         | )  |
|-----|---------------|---------------------------|--|--------------|-------|---|--------------|--------------------|----|
|     | CENTER        | S FOR MEDICARE &          | MEDICAID SERVICES  |              |       |   | OMB N        | O. 0938-0391       | -, |
|     |               | OF DEFICIENCIES           | (X1) PROVIDER/SUPPLIER/CLIA                                | (X2) M       | ULTII | IPLE CONSTRUCTION   | (X3) DATE SU |                    |    |
|     | AND PLAN OF   | CORRECTION                | IDENTIFICATION NUMBER:                                     | A. BUIL      | .DIN  | 4G  | COMPLET      |                    |    |
|     |               |                           | 245442   | B. WIN       | G     |   |              | С                  |    |
|     |               |                           | 345113   |              |       |   | 10/1         | 9/2012             | -  |
|     | NAME OF PR    | ROVIDER OR SUPPLIER       |  |              |       | REET ADDRESS, CITY, STATE, ZIP CODE                                 |              |                    |    |
|     | WILLOW        | CREEK NURSING AND R       | EHABILITATION CENTER                                       |              |       | 2401 WAYNE MEMORIAL DRIVE   |              |                    |    |
|     |               |                           |  | ,            |       | GOLDSBORO, NC 27534   |              | <del>,</del>       | _  |
|     | (X4) ID       |                           | ATEMENT OF DEFICIENCIES                                    | (D           |       | PROVIDER'S PLAN OF CORRECTION                                       |              | (X5)<br>COMPLETION |    |
|     | PREFIX<br>TAG |                           | Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION) | PREFI<br>TAG |       | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.) |              | DATE               |    |
|     |               |                           |  |              |       | DEFICIENCY)   |              |                    | -  |
|     |               |                           |  |              |       |   | ·            |                    | 1  |
|     | F 333         | Continued From page       | 35   | · F:         | 333   | 3 ,   |              |                    |    |
|     |               | the accurate medication   | on, dose, time, and route.                                 |              |       |   |              |                    |    |
|     |               |                           | nurses checked the MAR for                                 |              |       |   |              |                    |    |
|     |               |                           | f the month. For weekly                                    |              |       |   |              |                    |    |
|     |               |                           | es marked the MARS with                                    |              |       |   |              |                    |    |
|     |               |                           | rough the days it was not to                               |              |       |   |              |                    |    |
|     |               | be given. The nurses      |  |              |       |   |              |                    |    |
|     |               |                           | ne month were responsible                                  |              |       |   |              |                    |    |
|     |               |                           | new order was started onth, the nurse taking the           |              |       |   |              |                    |    |
|     |               |                           | for marking the MAR. The                                   |              |       |   |              |                    |    |
|     |               |                           | cted the staff to observe the                              |              |       |   |              | ļ                  |    |
|     |               | five rights of medication |  |              |       |   |              |                    |    |
|     |               | =                         | ck the MAR versus the label                                |              |       |   |              |                    | l  |
|     |               |                           | f staff was unfamiliar with                                |              |       |   |              |                    |    |
|     |               | the indication, dosage    |  |              |       |   |              |                    | ١  |
|     |               |                           | cted them to research the                                  |              |       |   |              |                    |    |
|     | 1             |                           | of the available references,                               |              |       |   |              |                    |    |
|     |               |                           | taff and/or the pharmacy. or the nurses that checked       |              |       |   |              |                    |    |
|     |               |                           | mark them to ensure that                                   |              |       |   |              |                    |    |
|     |               |                           | ess than daily were given                                  |              | :     |   |              |                    |    |
|     |               |                           | ated she considered the                                    |              |       |   |              |                    |    |
| -   |               |                           | methotrexate for resident                                  |              |       | ***************************************                             |              |                    |    |
|     | -             | #170 to be a significan   | nt medication error.                                       |              |       |   |              |                    |    |
|     | 1             | to a talanhana inta-d-    | W on 40/25/42 of 4/05DM                                    |              |       |   |              |                    |    |
| - 1 |               |                           | w on 10/25/12 at 4:05PM,<br>ted resident 170 in the ICU    |              |       | •   |              |                    |    |
| -   | 1             | stated she had multiple   |  |              |       |   |              |                    | ĺ  |
| 1   |               |                           | onic diseases, and debility.                               |              |       |   |              |                    |    |
|     |               |                           | he methotrexate may have                                   |              |       |   |              |                    |    |
| Í   |               |                           | fent's pancytopenia. He                                    |              |       |   |              |                    |    |
| -   |               | stated adverse reaction   | ns to methotrexate were                                    |              |       |   |              |                    |    |
|     |               |                           | s and it would take days                                   |              |       | -   |              | ;                  |    |
|     | 1             |                           | lear after it was stopped.                                 |              |       |   |              |                    |    |
|     |               |                           | e wasn't sure the amount                                   |              |       |   |              |                    |    |
|     | i i           |                           | sident received would be                                   |              |       |   |              |                    | İ  |
|     | 1             | considered an overdos     | · ·  |              | ĺ     |   |              |                    |    |
| - 1 | 1             | contributed to her cond   | mon and deam.  |              | ı     | [   |              |                    | J  |

|     | DEPART     | MENT OF HEALTH AN             | ID HUMAN SERVICES                                  |         |       |  |               | APPROVED           |   |
|-----|------------|-------------------------------|--|---------|-------|--|---------------|--------------------|---|
|     |            |                               |  |         |       |  | - +           | ). 0938-0391       |   |
|     | +          |                               | MEDICAID SERVICES                                  | 1,,,,,, |       | N C CONSTOUR                                 | (X3) DATE SUE | •                  | 1 |
|     |            | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M  | ULIN  | PLE CONSTRUCTION                             | COMPLET       |                    |   |
|     | 741010401  | COMICONOM                     |  | A. BUI  | LDING | 3  |               | ~                  |   |
|     |            |                               |  | B. WIN  | lG    |  | }             | 0                  |   |
|     |            |                               | 345113   | L       | ,     |  | 10/1          | 9/2012             | - |
|     | NAME OF PR | ROVIDER OR SUPPLIER           |  |         | STF   | REET ADDRESS, CITY, STATE, ZIP CODE          |               |                    |   |
|     | MILL OW    | ODEEN NIIDOING AND D          | EHABILITATION CENTER                               |         | 2     | 401 WAYNE MEMORIAL DRIVE                     |               |                    |   |
|     | WILLOW     | OVEEW HOKOMA WAD V            | CHABICHARION OCHTER                                |         | (     | GOLDSBORO, NC 27534                          |               |                    |   |
|     | (X4) ID    | SUMMARY STA                   | ATEMENT OF DEFICIENCIES                            | ID      |       | PROVIDER'S PLAN OF CORRECTE                  | ON            | (X5)               | 1 |
|     | PREFIX     | (EACH DEFICIENC)              | Y MUST BE PRECEDED BY FULL                         | PREF    |       | (EACH CORRECTIVE ACTION SHOUL                |               | COMPLETION<br>DATE |   |
|     | TAG        | REGULATORY OR I               | SC IDENTIFYING INFORMATION)                        | TAG     | ŧ     | CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |               |                    |   |
| -13 |            |                               |  |         |       |  |               |                    |   |
|     |            |                               |  |         |       |  |               |                    |   |
|     | F 333      | Continued From page           | e 36   | ·F      | 333   | erstore result maeri                         |               | -                  |   |
|     |            |                               |  |         |       | 84   |               |                    |   |
|     |            | The Administrator was         | s notified of the Immediate                        |         |       |  |               |                    |   |
|     |            | Jeopardy on 10/18/12          | at 5:55PM. The facility                            |         |       |  |               |                    |   |
|     |            | provided a credible al        | legation of compliance on                          |         |       |  |               |                    |   |
|     |            | 10/19/12 at 4:30PM.           | The allegation of                                  |         |       |  |               |                    |   |
|     |            | compliance indicated:         |  |         |       |  |               |                    |   |
|     |            |                               |  |         |       | [  |               |                    |   |
|     |            | · ·                           | # 6758 received an order for                       |         |       |  |               |                    |   |
|     |            | Methotrexate 2.5mg 4          | l=10mg po Q 7 days by the                          |         |       |  |               |                    |   |
|     |            | Physician. Resident #         | #6758 was administered                             |         |       |  |               |                    |   |
|     |            | Methotrexate per Phy          | sician 's order on 9/19/12                         |         |       |  |               |                    |   |
|     |            | and 9/26/12 by the Me         | edication Aide. Resident                           |         |       |  |               |                    |   |
|     |            | #6758 was assessed            | by the licensed Nurse on                           |         |       |  |               |                    |   |
| i   | ĺ          | 10/8/12 and was note          | d to have a blood pressure                         |         |       |  |               | •                  |   |
|     |            | of 90/50 and difficulty       | swallowing in which all 8pm                        |         |       |  |               |                    |   |
|     |            | blood pressure medic          | ations were held and the                           |         |       |  |               |                    |   |
|     |            | MD was notified in pe         | rson of Resident's change                          |         |       |  |               |                    |   |
|     |            | in condition by the lice      | ensed Nurse. On 10/8/12                            |         |       |  |               |                    | l |
|     |            | the MD assessed the           | Resident and wrote an                              |         |       |  |               |                    |   |
|     |            | order for Nystatin susp       | pension 5ml swish and spit                         |         |       |  |               |                    |   |
|     |            |                               | ng daily x 10days. Resident                        |         |       |  |               |                    |   |
|     |            | #6758 was reassesse           |  |         |       |  |               |                    |   |
|     |            |                               | omplained of sore mouth                            |         |       |  | İ             |                    |   |
| ļ   |            |                               | rtab 5/500 was administered                        |         |       |  | İ             |                    |   |
| -   |            |                               | On 10/10/12 Resident #                             |         |       |  |               |                    |   |
|     |            |                               | sed by the licensed Nurse                          |         |       |  |               |                    |   |
|     |            | •                             | ers were received to hold                          |         |       |  |               |                    |   |
|     |            | Prednisone and Plaqu          | - ·  |         |       |  |               |                    |   |
|     |            |                               | sic 25mcg patch change Q                           |         |       |  |               |                    |   |
| ļ   |            |                               | rmal saline @ 70 cc per                            |         |       |  |               |                    |   |
| 1   |            |                               | ident #6758 blood pressure,                        |         |       |  |               |                    |   |
| į   |            |                               | itus was assessed by the                           |         |       |  |               |                    | İ |
|     |            | licensed Nurse and the        |  |         |       |  |               |                    |   |
|     |            |                               | change in condition, new                           |         |       |  |               |                    |   |
|     | -          | •••••                         | send to ER for evaluation.                         |         |       |  |               |                    |   |
| -   |            |                               | m Resident was sent to the                         |         |       |  |               |                    |   |
| - 1 |            |                               | Director of Nursing was                            |         |       |  |               |                    |   |
| -   |            | informed the morning          | of 10/12/12 the resident                           |         |       |  |               |                    | İ |

PRINTED: 10/30/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES Ю (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 333 Continued From page 37 F 333 was deceased. All staff involved were drug tested 10/12/12. All results came back negative. The nurse was re-educated, drug tested and suspended on 10/12/12 and remains suspended at this time. The medication aides were re-educated. The facility has suspended use of medication aides. All medication aides are working as certified nursing assistants giving direct patient care. All other Residents prescribed Methotrexate initial orders were reviewed by the Director of Nursing for accuracy of transcription on to the MAR, blocking of the MAR for every seven day administration and to ensure the accuracy of the next scheduled dose of the medication on 10/11/12. There were no doses scheduled to be given at the time of the audit. Noted issues were corrected as identified on 10/11/12. Physical Assessments were completed on Residents on Methotrexate by licensed nurses and labs obtained by 10/12/12. The determination was made by the Director of Nursing after review of the medication administration record (MAR) that the orders were transcribed correctly to the MAR. The medication error was the direct result of the licensed/certified staff not following the six rights of medication administration (right resident, right medication, right dose, right route, right method, right time) resulting in the medication being administered incorrectly. The medication administration record not being blocked off for medication to be given every seven days was a contributing factor to the

medication error.

|   | DEPARTI           | MENT OF HEALTH AN                         | D HUMAN SERVICES               |   |       |   | FORM          | APPROVED           |   |
|---|-------------------|---|--------------------------------|---|-------|---|---------------|--------------------|---|
|   | CENTER            | S FOR MEDICARE & I                        | MEDICAID SERVICES              |   |       |   |               | 0. 0938-0391       | - |
|   |                   | OF DEFICIENCIES                           | (X1) PROVIDER/SUPPLIER/CLIA    | (X2) M                                  | ULTIF | PLE CONSTRUCTION  | (X3) DATE SUF |                    |   |
|   | AND PLAN OF       | CORRECTION                                | IDENTIFICATION NUMBER:         | A. BUI                                  | LDIN( |   | COMPLET       |                    |   |
|   |                   |   | 045440                         | 8. WIN                                  | IG    |   | 1             | C                  |   |
|   |                   |   | 345113                         |   |       |   | 10/1          | 9/2012             | ┨ |
|   | NAME OF PR        | OVIDER OR SUPPLIER                        |                                |   | 1     | REET ADDRESS, CITY, STATE, ZIP CODE<br>401 WAYNE MEMORIAL DRIVE |               |                    |   |
|   | WILLOW (          | CREEK NURSING AND R                       | EHABILITATION CENTER           |   | i     | SOLDSBORO, NC 27534   |               |                    |   |
|   |                   | CHIMADV CT/                               | ATEMENT OF DEFICIENCIES        | ID                                      | L_`   | PROVIDER'S PLAN OF CORRECT                                      | ION           | (X5)               | 1 |
|   | (X4) ID<br>PREFIX | (EACH DEFICIENCY                          | MUST BE PRECEDED BY FULL       | PREF                                    |       | (EACH CORRECTIVE ACTION SHOU                                    | LO BE         | COMPLETION<br>DATE |   |
|   | TAG               | REGULATORY OR L                           | SC IDENTIFYING INFORMATION)    | TAG                                     |       | CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)                    |               | 0/RC               |   |
|   |                   |   |                                |   |       |   |               |                    |   |
| i | F 333             | Continued From page                       | 38 -                           | · F                                     | 333   |   |               |                    |   |
| Ì | , , , ,           | The dispensing pharm                      |                                |   |       | -   |               |                    |   |
|   |                   |   | as being at high risk for      | -                                       |       |   |               |                    |   |
|   |                   |   | has taken steps in the         |   |       |   |               |                    |   |
|   |                   |   | ng process to minimize         |   |       |   |               |                    |   |
|   |                   | administration error po                   | otential.                      | 1                                       |       |   |               |                    |   |
| ı |                   | 1. Methotrexate- Effect                   | ctive 10-17-12 the following   |   |       |   |               |                    |   |
| 1 |                   | changes for dispensin                     |                                |   |       |   |               |                    |   |
|   |                   |   | ing with the medication        | •                                       |       |   |               |                    |   |
|   |                   | delivery on 10-17-12:                     |                                |   |       |   |               |                    |   |
| ı |                   | -Package all Methotre                     | xate orders in bingo           |   |       |   | •             | :                  |   |
| ١ |                   |   | he drug is dispensed from      | -                                       |       |   | ;             |                    |   |
| ı |                   | the pharmacy                              |                                |   |       |   | :             |                    |   |
|   |                   |   | supply each time the drug is   |   |       |   |               |                    |   |
|   |                   | dispensed from the ph                     | ary wording, **NOTE DOSE       |   |       |   |               |                    | İ |
| ١ |                   |   | *** in sig (directions), place |   |       |   |               |                    |   |
| ١ | İ                 | а   |                                |   |       |   |               |                    |   |
| İ |                   |   | ion auxiliary label on the     |   |       |   |               |                    |   |
| l |                   | -Move Methotrexate to                     | 'HIGH ALERT CAUTION"           |   |       |   |               | :                  |   |
|   |                   | pharmacy                                  |                                | 1                                       |       |   |               |                    |   |
| I |                   | -Have Registered Pha                      | rmacist double check final     |   |       |   | :             |                    | Ì |
| l |                   |   | nitial review each time the    | İ                                       |       |   |               |                    |   |
| ١ |                   | drug is dispensed from                    | tne pnarmacy.                  | -                                       |       |   |               |                    |   |
|   | Tremore           | 2. Concentrated liquid                    | morphine and oxycodone:        | -                                       |       |   |               |                    |   |
| ſ |                   | 1) A "stop-sign shap                      | ed" red auxiliary label that   | 1                                       |       |   |               |                    |   |
|   |                   |   | ble-Check" affixed to each     | *************************************** |       |   |               |                    |   |
| 1 |                   | bottle dispensed to a r                   | esident or for the             |   |       |   |               |                    |   |
|   |                   | emergency drug kit<br>2) A mini-monograph | with conversion arid           | 1                                       |       |   |               |                    |   |
| ۱ |                   | dispensed with each t                     |                                |   |       |   |               |                    |   |
| I |                   | printed on bright pink/r                  |                                | Í                                       |       |   |               |                    |   |
|   |                   |   | ement is added to each         | İ                                       |       |   |               |                    |   |
|   |                   | concentrated morphine                     |                                |   | İ     |   |               |                    | l |
| 1 |                   | prescription label and I                  | MAR, "Double-check dose.       | l                                       | - [   |   | 1             |                    | í |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY). F 333 Continued From page 39 F 333 Use calibrated syringe." 4) Calibrated oral dosing syringe is dispensed bottle. 3. For Warfarin products exclamation points are placed before the medication name on the MAR/product label 4. "Tall Man" letters are used for sound alike and look alike drug names on the MAR/product label (per the ISMP - institute for safe medication practice - suggested list). Methotrexate, for the Residents continuing to receive the medication have been returned to the pharmacy upon receipt of the 10-17-12 delivery. Validating of Methotrexate doses occurred by 2 licensed Nurses prior to Administration until new packaging was available. Signage to alert staff of Residents receiving Methotrexate and the need to verify dose with a second Nurse was inserted in the Resident's Medication Record. The new packaging arrived in the facility on 10/17/12. Medications in the old packaging have been returned to the pharmacy. As a precautionary measure on 10/12/12 the facility temporarily suspended the use of Medication Aides pending medication administration retraining and a medication pass audit by the Pharmacy Consultant or an Administrative Nurse. The retraining of certified medication aides will include, but will not be limited to: the six rights of medication administration the importance of reading and understanding medication labels and orders being aware of special instructions/alerts on

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Facilitator related to the Six Rights of Medication

PRINTED: 10/30/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 333 Continued From page 41 F 333 Administration, Blocking the MAR for Medications given less than daily, Notification of MD and RP of significant change in condition and the Signs and Symptoms of Methotrexate toxicity. In-service was started on 10/12/12 by the Staff Facilitator for the certified Nursing Assistants on change in Resident conditions that need to be reported to the Nurse. Staff will be in-serviced prior to beginning their shift, to include staff on vacation and those that only work weekends. Nursing Assistants hired after 10-12-12 will be in-serviced during their orientation process by the Staff Facilitator related to the Changes in Resident conditions that need to be reported to the Nurse. An Interview Tool has been developed related to in-servicing material covered with Nurses and Medication Aides related to the Six Rights of Medication Administration, Blocking the MAR for Medications given less than daily, Notification of MD and RP of significant change in condition and the Signs and Symptoms of Methotrexate toxicity. Implementation of the interview tool will occur on 10-18-12. All nurses will be interviewed by an Administrative Nurse prior to the beginning of their scheduled shift. The Staff Facilitator or Administrative nurse will use the interview tool on one nurse per shift for 4 weeks, then one nurse daily for 4 weeks. Results of interviews will be reviewed weekly by the Quality Improvement Committee. On 10/12/12 a review of all current MARs was

initiated by licensed nurses to include MDS Nurses, QI Nurse, Treatment Nurses and ADON

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 333 Continued From page 42 F 333 with assistance and oversight by Director of Nursing to include comparison of October MAR to the September MAR and telephone orders to ensure medications are being administered as ordered. Medication used less than daily were reviewed to ensure the MAR was blocked off. Issues were corrected as identified during the review by the licensed Nurse. Corrections were completed on 10-17-12. Beginning 10/12/12 the licensed Nurses reviewed nurse notes on all Residents from 9/11/12 to 10/12/12 ensure there are no acute issues that have not been addressed. A general assessment was completed on each Resident by a licensed Nurse to ensure Residents did not have a change in condition that warranted the notification of the MD and/or RP. Identified issues were addressed as indicated by the licensed Nurse. On 10/12/12 Medication Administration audits were started for all licensed Nurses and were completed by 10/19/12. The medication audits consist of the use of a Medication Pass Audit Form developed by the pharmacy which consists of observation of multiple medications and requiring a less than 5% error rate to pass. Concerns were addressed by the auditing Nurse at the time of the observation. Nurses with a Med Pass error rate of 5% or greater received a second Med Pass Audit by an Administrative Nurse. Nurses hired after 10-19-12 will receive a Med Pass audit within 2 weeks of completion of the Orientation process. The Med Pass audit will be completed by an Administrative Nurse. Beginning 10/12/12, all telephone orders will be

reviewed by the Administrative Nurse to ensure

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|  | 345113  | B. WING                    |   | 1                      | C<br>19/2012               |
| NAME OF PROVIDER OR SUPPLIER WILLOW CREEK NURSING AND  | REHABILITATION CENTER   | 24                         | EET ADDRESS, CITY, STATE, ZIP CODE<br>401 WAYNE MEMORIAL DRIVE<br>OLDSBORO, NC 27534              |                        |                            |
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| for medications give medication administ the telephone orders 6 weeks and then as the QI team.  Beginning 10/12/12 Administrative Nurse ensure medications daily are blocked off administered as ordeweekly 6 weeks and necessary by the QI Beginning 10/12/12 Methotrexate will be Administrative Nurse ensure accurate administrative Nurse ensure accurate administrative Nurse ensure accurate administrative Nurse ensure accurate administrative Nurse ensure accurate administrative Nurse ensure accurate administrative Nurse ensure accurate administrative Nurse ensure accurate administrative Nurse ensure accurate administrative Nurse ensure accurate administrative Nurse ensure accuracy of the nurse of the nurs | on and blocking of the MARS on less than daily on the ration record using copies of staily x 14 days, 3 x weekly x as determined necessary by  MARS will be reviewed by the example of the ware given less than from the MAR and are being ered daily x 14 days, 3 x and then as determined team  the MARs of residents taking reviewed by the example of the medication weekly x 6 weeks and then as rry by the QI team.  Invember MAR, the MAR proporate a third check by two the first day of the month to the November MAR and to the signer less than daily have | · F 333                    | DEFICIENTS  |                        |                            |

PRINTED: 10/30/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 333 Continued From page 44 F 333 check will sign off on each hard copy and use a current census as the audit tool to show completion of the audit. Audit will be completed by the end of the first day of the new month. Results of the audit will be reviewed and addressed weekly by the Director of Nursing or the designee. The results will be compiled and forwarded to the Quality Improvement Committee for weekly review of identification of trends. development of action plans and to determine the need and /or frequency of continuing QI monitoring. On 10/19/12 at 5:59PM, the credible allegation of compliance was validated by observations. interviews, and record review. The facility provided evidence of in-service training for all nursing staff and medication aides. In-services included medication administration, special precautions, dosage, packaging, MAR blocking, and side effects/toxicity of methotrexate. Audit tools and forms were reviewed. Record review of other sampled residents receiving methotrexate revealed the medication was given according to the physician's orders. MARS were appropriately blocked off to ensure once weekly dosing. Observation revealed methotrexate orders were packaged in bingo cards with only a one week supply dispensed from the pharmacy. Cautionary labels and the MARS read \*\*NOTE DOSE AND FREQUENCY!!! Other high risk medications were also labeled with cautionary labels. Interviews with all nursing staff on duty were conducted and revealed competency regarding medication administration, special

precautions, dosage, packaging, MAR blocking, and side effects/toxicity of methotrexate.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING C B. WING 345113 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ŧΩ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 333 Continued From page 45 F 333 Interviews revealed the medication aides were no longer administering medications. Interviews revealed in-services and audits had been completed and were ongoing. Interview with the Regional Clinical Pharmacist revealed dispensing, packaging, and labeling changes for methotrexate and other high risk medications had been implemented. Medication pass observations had been completed and were ongoing. Interviews with the Administrator, DON, and administrative staff revealed monitoring tools were in place and education of the staff was ongoing. The interviews revealed active and ongoing monitoring of policy implementation.