STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR HEIGHTS CENTER	804 SOUTH POPULAR STREET ELIZABETHTOWN, NC 28337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review, the facility failed to prevent significant medication errors by administering the wrong medications to 1 of 2 residents (Resident #1) resulting in the resident's hospitalization and need for medical treatment for drug overdose and exacerbation of symptoms of heart disease. Findings included: Resident #1 was admitted to the facility on 12/07/12 with cumulative diagnoses of congestive heart failure, atrial fibrillation, anemia and chronic kidney disease. In an interview with the Director of Nursing (DON) on 05/21/13 at 9:15 AM, she stated that she was aware of a medication error which occurred on 05/17/13. Review of the facility investigation notes (time line of events) written by the DON on 5/17/13, revealed that Nurse #1 poured Resident #1's morning medications (Coreg, Digoxin, Cardizem, Aldactone, Zaroxolyn and Aspirin are heart medication). When she entered the room the resident was not in the room. Resident #1 had gone outside with the activities department to watch flower planting. Nurse #1 covered the medication cup with another cup and placed both cups in the top drawer of the medication cart. Nurse #1 then proceeded to pass medications on	F 333	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Poplar Heights Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." F 333 1. Resident #1 readmitted to facility on 5/29/2013. Nurse caring for resident #1 on 5/17/2013 received 1:1 education and training on medication administration and prevention of medication errors on 5/17/2013. 2. Residents receiving medications by licensed nurses in the facility have the potential to be affected. Education and training on medication administration and prevention of medication errors was started initially on 5/17/2013 and was	6/12/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa B. Alagia NHA — TITLE: Administrator — (X6) DATE: 6/12/13

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.

J.F

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F 333	Continued From page 1 her assigned hall. Nurse #1 had poured Resident #2's medications when Resident #1 rolled up to the medication cart and requested her medications. Nurse #1 then retrieved Resident #1's medication cup from the top drawer of the medication cart. She asked Resident #1 if she wanted juice or water. When Nurse #1 turned from pouring the water, she picked up Resident #2's medication cup and handed it to Resident #1 to take. Resident #1 took the cup and swallowed the medications. Review of the Interdisciplinary note of 5/17/13 revealed Resident #1 received the following medications; Norvasc 10 milligram (mg), Vasotec 10 mg, Clonidine 0.2 mg, Toprol XL 50 mg, (all blood pressure medications); Percocet 7.5/325 mg (Opiate), Lyrica 100 mg (pain killer), Buspar 10 mg (antianxiety medication), Paxil 30 mg (antidepressant medication), Oxybutynin 5 mg (bladder spasms), multivitamin, Prilosec 40 mg, Colace 100 mg, Mag-Oxide 400 mg and Aspirin 81 mg. Resident received 15 medications in error. In an interview on 05/21/13 at 11:29 AM, Nurse #1 revealed that she realized that she gave Resident #1 the wrong medications as soon as the resident swallowed the medications. She told Resident #1 to spit the medications out and the Resident replied, "They're gone" meaning she had swallowed them. Nurse #1 stated she locked the medication cart and called for the RN supervisor, as noted on the facility timeline written by the DON at 11AM. Nurse #1 surrendered her keys to the medication cart to the RN supervisor and was sent to the Director of Nursing office. Review of the timeline of events of 5/17/13 revealed on 11:15 AM the DON ordered that the	F 333	completed on 5/22/2013 for all licensed nurses. This education and training was provided by the Director of Nursing and the Assistant Director of Nursing. 3. The Director of Nursing, Assistant Director of Nursing, and Unit Managers will observe nurses during medication administration 2 x per week x 1 month, weekly x 1 month, then monthly x 1 month to ensure interruptions during the medication pass are handled appropriately, medications are prepared, administered, and documented per facility policy. Medication administration observations will be completed with random nurses covering all 3 shifts. Nurses identified as requiring additional education and training during the observations will receive 1:1 education by the Director of Nursing. 4. Results of the medication administration observations will be reviewed by the Performance Improvement Committee monthly x 3 months for further recommendations.	

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F 333	Continued From page 2 resident be placed on 1:1 monitoring by a CNA and to take vital signs every 15 minutes. The RN supervisor called the doctor at 11:25 AM who ordered vital signs every 15 minutes and to call him back if there was any change in condition. A family member of Resident #1 came to visit at 11:45 AM and was notified of the error and measures ordered by the attending physician. Review of a Nurses note written by the DON on 5/17/13 (untimed) revealed that from 11:00 AM (when the error occurred) until 12:45 PM, the resident's pulses [60-72], respirations [20] and blood pressures [120/70 -140/80] remained stable. The resident's family members returned to the facility at 1:10 PM and noted the resident with shallow breathing. Vital signs reading decreased to pulse [54], respirations [14] blood pressure of 100/50. The family member was quoted in the note "She looks like she is not breathing". The nurses responded to assess the resident. The resident had shallow breathing but was aroused by sternal rub. Once the resident became awake, the resident was verbally responsive but drowsy. The staff called 911 at 1:15 PM and EMS (Emergency Medical Services) arrived 1:20 PM. Review of the time line of event of 5/17/13 revealed the RN supervisor called the local hospital ED (emergency department) at 1:33 PM, while the resident was en route, to review with the hospital nurse what medications had been given in error. Nurse #1 was counseled, reeducated and suspended.	F 333		

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F 333	Continued From page 3 Resident #1 was admitted to the local hospital on 05/17/13 at 1:45 PM with working diagnoses of "Drug overdose (OD), Bradycardia (low heart rate) unstable BP (blood pressure) due to drug OD (overdose)." The resident's hospital admission records revealed her vital signs were BP of 123/47 (normal 130-80), pulse 52 and irregular (normal 60-100). She was placed on cardiac monitoring which indicated "atrial fibrillation with pulse rates of 40-70)." "In the Emergency Department the patient was slightly lethargic and her blood pressure was labile (unsteady). She had an episode of transient Bradycardia (pulse rate dropped to 40 beats per minute) and we are placing her in the ICU (intensive care unit) under observation for further monitoring, evaluation and treatment." Narcan (reverses the lethargy and decreases respirations exhibited with opiate overdose) was administered at 4:29 PM to reverse the effects of the Percocet (opiate) that the resident had received as part of the 15 medication given at 11 AM. A note dictated by the hospitalist on 05/17/13 at 6:29 PM indicated creatinine (measure of kidney function) was 2.5 (normal for this patient is 2.0 from nursing home records) and EKD (electrocardiogram) "showed atrial fibrillation with a variable rate between 41-61 beats per minute (normal=60-100) and left bundle branch block (delay or obstruction along the pathway that electrical impulses travel to make your heart beat)." An ICU nurses note on 05/17/13 at 7:45 PM revealed atrial fibrillation of 50-70 with both lungs clear. At 8:30 PM her blood pressure dipped to 80s/40s. The medical doctor (MD) was notified and started the resident on a Dopamine drip. Lexi-comps Geriatric Dosage	F 333		

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F 333	Continued From page 4	F 333		

Handbook, 17th edition stated that Dopamine is used as an adjunct treatment in shock (renal failure and cardiac decompensation (functionality)). At 10 PM her heart rate and BP were back up [136/60, HR=65] but she was not urinating. The MD was notified and increased her intravenous fluid rate to 75 cc per hour.

On 05/18/13 laboratory assay revealed that the resident ' s creatinine has risen to 3.0 indicating worsening kidney function. IVF (intravenous fluids) were reduced to 35 mg/ hour at 6 PM.

On 05/19/13 at 8:50 AM ICU nurses notes indicated resident complained of shortness of breath. Her oxygen saturations were dropping to 89-90% (normal =100%) and her heart rate was 120 and irregular. At 9:10 AM, MD notes indicated the MD ordered for the resident to have an EKG for shortness of breath, a portable chest x-ray now, a beta-natriuretic (BNP) to assess for worsening congestive heart failure, cardiac tropins to rule out myocardial infarction (heart attack), and Coreg to regulate heart beat. Both BNP (indicative of congestive hearth failure) and tropin levels returned as significantly elevated. Chest x-ray results indicated "There has been slight interval of congestive cardiac failure and bilateral (both lungs) pleural effusions are present (fluid in both lungs)." On 05/19/13 at 8:15 PM the resident again complained of shortness of breath and the attending physician's notes indicated tachycardia (fast heart rate) of 135 [abnormal range of 127-140s], decreased oxygen saturation of 87, definitive congestive heart failure and the necessity to start IV diuretic (Push Lasix IV 40 mg). The resident's blood pressure at this note was 167/110.

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F 333	Continued From page 5 On 05/20/13 at 8:15 AM the attending physician noted acute pulmonary edema. The resident remained at the hospital as of 05/24/13.	F 333		