

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

PRINTED: 09/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2014
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306		
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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and record review, the facility failed to medicate 1 of 1 (Resident #334) residents reviewed for post-operative pain. Findings included:</p> <p>Resident #334 was admitted to the facility on 7/3/14 at 5:30 PM with a diagnosis of osteoarthritis and status post partial right knee replacement on 6/30/14. Resident #334 was discharged home on 7/29/14 after receiving therapy services. The nursing admission note dated 7/3/14 at 6:36 PM indicated Resident #334 arrived at the facility at 5:30 PM. She was alert and oriented to person, place and time. Resident #334 was able to voice needs and expressed a pain score of 8 out of 10 with 10 being the highest level of pain. The nurse assessed the surgical site noting a small amount of light pink drainage to the site. The area was cleaned and redressed as ordered.</p> <p>A review of the hospital discharge medication list dated 7/3/14 indicated the physician ordered Lyrica (medication used to treat nerve pain) 75milligrams (mg) by mouth every 8 hours for pain, Oxycontin (opioid pain medication) 40 mg</p>	F 309	<p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>Resident discharged on 07/29/2014 Nurse #1 and Nurse #2 were counselled for failing to follow facility policy/procedure for ordering, receiving, and administering medications. Nurse #1 and Nurse #2 were in-serviced on facility policy/procedure for ordering, receiving, administering medications and pain management, including identifying signs/symptoms and addressing pain. Completion Date: 09/22/2014</p> <p>How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice</p> <p>All new admissions, since 08/27/2014, were audited to determine if medications</p>	9/22/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/17/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	<p>Continued From page 1</p> <p>by mouth every 8 hours for pain and Oxycodone (opioid pain medication) 5 mg tablets 1 tablet for pain score 1-3, 2 tablets for pain score from 4-6, and 3 tablets for pain score 7-10. On review of the hospital medication administration record (MAR) dated 7/3/14, Resident #334 received Lyrica, Oxycontin and Oxycodone at 1:43 PM prior to discharge.</p> <p>A review of facility records revealed evidence that the original prescriptions for the Lyrica, Oxycontin and Oxycodone were provided by the hospital to the facility for Resident #334 on 7/3/14. The facility ' s physician orders indicated Resident #334 was to have Oxycontin 40mg by mouth at 10:00 PM, 6:00 AM and 2:00 PM and Lyrica 75 mg by mouth at 10:00 PM, 6:00 AM and 2:00 PM. Oxycodone 5 mg was ordered every 4 hours for pain based on the same pain score system the hospital used. The admission orders also indicated a pain assessment to be done on each shift.</p> <p>A review of the facility's MAR revealed Resident #334 did not receive the 10:00 PM dose of Lyrica on 7/3/14 or the 6:00 AM dose of Lyrica on 7/4/14. Resident #334 also did not receive the 10:00 PM dose of Oxycontin on 7/3/14 or the 6:00 AM dose of Oxycontin on 7/4/14. A review of the MAR revealed no prn doses of Oxycodone were given until 7/4/14 at approximately 11:45 AM when her medications arrived from the pharmacy. It was at this time, she also received her scheduled Lyrica and Oxycontin. A review of the MAR indicated a pain assessment was done on first and second shift daily but five pain assessments were done on night shift during her stay from 7/3/14 to 7/29/14.</p>	F 309	<p>were given appropriately after admission and pain assessment completed, by the Director of Nursing, Staff Development Coordinator and Unit Managers. Completion Date: 09/22/2014</p> <p>All licensed nursing staff have been in-serviced on facility policy/procedure for ordering, receiving, administering medications and pain management, identifying signs/symptoms. All newly hired licensed nurses will receive in-service training on facility policy/procedure for ordering, receiving, administering medications, and pain management, including identifying signs/symptoms, at orientation. Completion Date: 09/22/2014</p> <p>Directed in-service on medication administration provided to all licensed nursing staff. Completion Date: 9/22/2014</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur</p> <p>Unit Managers and/or Director of Nursing will audit all new admission physician orders, pain management assessments and interventions 5 times per week for 4 weeks, bi-weekly times 4 weeks, then monthly times 1 month, to ensure compliance with facility policy/procedure for ordering, receiving, and administering medications. Results of the audits will be reviewed in the Quality Assurance Risk Meeting</p>		

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F 309	<p>Continued From page 2</p> <p>A nursing note dated 7/4/14 at 2:02 PM read in part, " previous complaint of right leg/knee pain 10/10 addressed with scheduled and prn pain meds once arrived from pharmacy. Lyrica, Oxycodone and Oxycontin given at approximately 1145. Pt did state she was going through withdrawal pain before meds arrived and were given. " This same nursing note also indicated the following, " therapy evaluations pending, pt was unable to complete PT eval d/t increased pain to right knee. " The nursing note further indicated Resident #334 was experiencing pain rated at a 10 of 10 and she refused therapy evaluations on 7/4/14 due to pain.</p> <p>In a telephone interview on 9/8/14 at 2:20 PM Nurse #1 stated indicated she administrated Resident #334's scheduled Oxycontin, Lyrica and prn Oxycodone at 11:45 AM when it arrived from pharmacy. Nurse #1 recalled Resident #334 voicing pain on 7/4/14 prior to her pain medications arriving from the pharmacy. Nurse #1 recalled offering Resident #334 Tylenol but she refused it stating she would wait for her medications to arrive from the pharmacy. Nurse #1 stated Resident #334 did not express outward indicators of pain but she did refuse her therapy evaluations on 7/4/14 citing pain as her reason.</p> <p>In a telephone interview on 9/8/14 at 2:40 PM Nurse #2 stated she worked night shift and could not recall on 7/3/14 if Resident #334 complained of post operative pain that night. She stated the second shift nurse gave Resident #334 her medications that were available before she left that night but Nurse #2 stated she did not have her 6:00 AM pain medications (Lyrica and Oxycontin) to give to Resident #334. She recalled reporting this to the nurse who was relieving her</p>	F 309	<p>weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month. Any areas identified will be corrected immediately and licensed nursing staff will be in-serviced to changes in the current plan. Completion Date: 09/22/2014</p> <p>How the facility plans to monitor its performance to make sure the solutions are sustained</p> <p>All results of the physician order and pain management audits will be reviewed in the Quality Assurance meeting monthly times 3 months, then quarterly times 3 quarters, and as needed. Completion Date: 09/22/2014</p>		

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F 309	<p>Continued From page 3</p> <p>that morning. Nurse #2 stated Resident #334 often slept through the night and she did not wake her up to do a pain assessment.</p> <p>In a telephone interview on 9/8/14 at 4:17 PM, the facility physician stated the facility pharmacist could have contacted the emergency backup pharmacy for earlier delivery or used the emergency drug stock if Resident #334 was expressing pain.</p> <p>In an interview on 9/8/14 at 4:45 PM, the DON stated Resident #334 verified Resident #334 did not receive her prescribed Lyrica and Oxycontin on 7/3/14 at 10:00 PM and at 6:00 AM on 7/4/14. The DON also provided evidence that Nurse #3 went into the emergency drug stock on 7/3/14 at 11:29 PM and removed Oxycontin 10mg and Oxycodone 5 mg for Resident #334 but could not provide documentation of Resident #334 receiving the pain medications.</p> <p>In an interview on 9/8/14 at 4:45 PM Nurse #3 stated Resident #334 did not arrive until around 5:30 PM on 7/3/14 and she was very busy that day. She stated she did a quick assessment on Resident #334 around 6:00 PM and noted that she had no complaints of pain but was up in the room and actively moving about. She recalled offering Resident #334 Tylenol at that time but she refused it. Nurse #3 stated Resident #334 complained of pain toward the end of her shift so she gave her Oxycontin 10mg and Oxycodone 5mg from the emergency drug stock at 11:29 PM but she did not document giving Resident #334 the pain medications.</p> <p>In an interview on 9/8/14 at 5:15 PM the Administrator stated she would have expected</p>	F 309			

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F 309	Continued From page 4 Resident #334 to have gotten her pain medication as ordered post-operatively.	F 309			
F 333 SS=D	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 and physician interviews and record review, the facility failed to provide prescribed pain medications for 1 of 4 (Resident #334) residents reviewed for medication administration. Findings included: Resident #334 was admitted to the facility on 7/3/14 at 5:30 PM with a diagnosis of osteoarthritis and status post partial right knee replacement on 6/30/14. Resident #334 was discharged home on 7/29/14 after receiving therapy services. The nursing admission note dated 7/3/14 at 6:36 PM indicated Resident #334 arrived at the facility at 5:30 PM. She was alert and oriented to person, place and time. Resident #334 was able to voice needs and expressed a pain score of 8 out of 10 with 10 being the highest level of pain. The nurse assessed the surgical site noting a small amount of light pink drainage to the site. The area was cleaned and redressed as ordered. A review of the hospital discharge medication list dated 7/3/14 indicated the physician ordered Lyrica (medication used to treat nerve pain) 75milligrams (mg) by mouth every 8 hours for pain, Oxycontin (opioid pain medication) 40 mg	F 333	How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident discharged on 07/29/2014 Nurse #1 and Nurse #2 were counselled for failing to follow facility policy/procedure for ordering, receiving, and administering medications. Nurse #1 and Nurse #2 were in-serviced on facility policy/procedure for ordering, receiving, and administering medications. Completion Date: 09/12/2014 How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice All new admissions, since 08/27/2014, were audited to determine if medications were given appropriately after admission, by the Director of Nursing, Staff Development Coordinator and Unit	9/22/14	

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F 333	<p>Continued From page 5</p> <p>by mouth every 8 hours for pain and Oxycodone (opioid pain medication) 5 mg tablets 1 tablet for pain score 1-3, 2 tablets for pain score from 4-6, and 3 tablets for pain score 7-10. On review of the hospital medication administration record (MAR) dated 7/3/14, Resident #334 received Lyrica, Oxycontin and Oxycodone at 1:43 PM prior to discharge.</p> <p>A review of facility records revealed evidence that the original prescriptions for the Lyrica, Oxycontin and Oxycodone were provided by the hospital to the facility for Resident #334 on 7/3/14. The facility ' s physician orders specified Resident #334 was to receive Oxycontin 40mg by mouth at 10:00 PM, 6:00 AM and 2:00 PM and Lyrica 75 mg by mouth at 10:00 PM, 6:00 AM and 2:00 PM. Oxycodone 5 mg was ordered every 4 hours for pain based on the same pain score system the hospital used.</p> <p>A review of the facility's MAR revealed Resident #334 did not receive the 10:00 PM dose of Lyrica on 7/3/14 or the 6:00 AM dose of Lyrica on 7/4/14. Resident #334 also did not receive the 10:00 PM dose of Oxycontin on 7/3/14 or the 6:00 AM dose of Oxycontin on 7/4/14. A review of the MAR revealed no prn doses of Oxycodone were given until 7/4/14 at approximately 11:45 AM when her medications arrived from the pharmacy. It was at this time, she also received her scheduled Lyrica and Oxycontin.</p> <p>A nursing note dated 7/4/14 at 2:02 PM read in part, " previous complaint of right leg/knee pain 10/10 addressed with scheduled and prn pain meds once arrived from pharmacy. Lyrica, Oxycodone and Oxycontin given at approximately 1145. Pt did state she was going through</p>	F 333	<p>Managers. Completion Date: 09/16/2014 All licensed nursing staff have been in-serviced on facility policy/procedure for ordering, receiving, and administering medications. All newly hired licensed nurses will receive in-service training on facility policy/procedure for ordering, receiving, and administering medications at orientation. Completion Date: 09/16/2014</p> <p>Directed in-service on medication administration provided to all licensed nursing staff. Completion Date: 9/22/2014</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur</p> <p>Unit Managers and/or Director of Nursing will audit all new admission physician's orders 5 times per week for 4 weeks, bi-weekly times 4 weeks, then monthly times 1 month, to ensure compliance with facility policy/procedure for ordering, receiving, and administering medications. Results of the audits will be reviewed in the Quality Assurance Risk Meeting weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month. Any areas identified will be corrected immediately and licensed nursing staff will be in-serviced to changes in the current plan. Completion Date: 09/16/2014</p>		

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F 333	<p>Continued From page 6</p> <p>withdrawal pain before meds arrived and were given." The nursing note further indicated Resident #334 was experiencing pain rated at a 10 of 10 and she refused therapy evaluations on 7/4/14 due to pain.</p> <p>In a telephone interview on 9/8/14 at 2:20 PM Nurse #1 stated indicated she administrated Resident #334's scheduled Oxycontin, Lyrica and prn Oxycodone at 11:45 AM when it arrived from pharmacy. Nurse #1 recalled Resident #334 voicing pain on 7/4/14 prior to her pain medications arriving from the pharmacy. Nurse #1 recalled offering Resident #334 Tylenol but she refused it stating she would wait for her medications to arrive from the pharmacy. Nurse #1 stated Resident #334 did not express outward indicators of pain but she did refuse her therapy evaluations on 7/4/14 citing pain as her reason.</p> <p>In a telephone interview on 9/8/14 at 2:40 PM Nurse #2 stated she worked night shift and could not recall on 7/3/14 if Resident #334 complained of post operative pain that night. She stated the second shift nurse gave Resident #334 her medications that were available before she left that night but Nurse #2 stated she did not have her 6:00 AM pain medications (Lyrica and Oxycontin) to give to Resident #334. She recalled reporting this to the nurse who was relieving her that morning.</p> <p>In an interview on 9/8/14 at 3:00 PM the director of nursing (DON) stated the facility had the original prescriptions for the ordered medications when Resident #334 was admitted. The DON stated Resident #334 arrived at the facility after 5:00 PM the day before a holiday. The on-call pharmacist would have gone into the office to</p>	F 333	<p>How the facility plans to monitor its performance to make sure the solutions are sustained</p> <p>All results of the physician order audits will be reviewed in the Quality Assurance meeting monthly times 3 months, then quarterly times 3 quarters, and as needed. Completion Date: 09/16/2014</p>		

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F 333	<p>Continued From page 7</p> <p>process the prescriptions or the pharmacist would have contacted a back up pharmacy to get the medications faster than they did. The DON verified Resident #334 did not receive her prescribed Lyrica and Oxycontin on 7/3/14 at 10:00 PM and at 6:00 AM on 7/4/14.</p> <p>In a telephone interview on 9/8/14 at 4:17 PM, the facility physician stated the facility pharmacist could have contacted the emergency backup pharmacy for earlier delivery or used the emergency drug stock if Resident #334 was expressing pain.</p> <p>In an interview on 9/8/14 at 4:45 PM, the DON stated she spoke with the pharmacist and the medications were put in as a STAT (rush) order but at best, they would not have gotten to the facility until the next day. The DON stated when a new admission was accepted she reviewed the physician orders and medications to ensure the facility had everything needed prior to the resident 's admission. She could not recall what time she reviewed Resident #334's admission paperwork for approval but referred to the copies of the original prescriptions dated as faxed on 7/3/14 at 6:17 PM. The DON could not verify if the facility received the fax at that time or if that was the time the facility faxed the prescriptions to the pharmacy. The DON also provided evidence that Nurse #3 went into the emergency drug stock on 7/3/14 at 11:29 PM and removed Oxycontin 10mg and Oxycodone 5 mg for Resident #334 but could not provide documentation of Resident #334 receiving the pain medications.</p> <p>In an interview on 9/8/14 at 4:45 PM Nurse #3 stated Resident #334 did not arrive until around 5:30 PM on 7/3/14 and she was very busy that</p>	F 333			

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F 333	<p>Continued From page 8</p> <p>day. She stated she did a quick assessment on Resident #334 around 6:00 PM and noted that she had no complaints of pain but was up in the room and actively moving about. She recalled offering Resident #334 Tylenol at that time but she refused it. Nurse #3 stated Resident #334 complained of pain toward the end of her shift so she gave her Oxycontin 10mg and Oxycodone 5mg from the emergency drug stock at 11:29 PM but she did not document giving Resident #334 the pain medications.</p> <p>In an interview on 9/8/14 at 5:15 PM the Administrator stated she would have expected Resident #334 to have gotten her pain medication as ordered post-operatively.</p>	F 333			