STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

(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 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the medication pass, resident, staff, nurse practitioner and physician interview, and record review, the facility failed to ensure a medication error rate less than 5% as evidenced by 2 errors (inhalation and blood pressure medications) out of 29 opportunities which resulted in a medication error rate of 6.8% for 2 of the 5 residents observed during the medication pass. (Residents #9 and #10). The findings included: 1. Resident #9 was admitted to the facility on 05/27/15 with diagnoses which included spinal cord injury. Admission medications included to inhale one puff of Advair Diskus 250-50 micrograms into the lungs daily to treat the constriction of airway. (The manufacturer of Advair Diskus recommends exhaling prior to inhalation for maximum drug benefit.) Review of Resident #9's admission Minimum Data Set dated 06/03/15 revealed an assessment of intact cognition. Observation on 06/16/15 at 8:04 AM revealed Nurse #1 handed the Advair Diskus to Resident #9. Nurse #1 did not ask Resident #9 to exhale prior to inhalation. Resident #9 did not exhale prior to the inhalation of one puff and inhaled one	F 332	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F332 1. Resident # 1 is no longer in the facility. Resident # 2 has had metoprolol discontinued. 2. Current licensed nurses will be in-serviced on orally inhaled medications using the Omnicare Medication Review for orally inhaled medications, including explaining to the resident to exhale prior to taking medication. Current licensed nursing staff will be in-serviced on specific parameters for blood pressure medications. The Medical Director has stated that the blood pressure medication be held for any blood pressure less than	7/20/15

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

Electronically Signed | 07/02/2015

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F 332	Continued From page 1 puff. Interview with Nurse #1 on 06/16/15 at 8:10 AM revealed she forgot to instruct Resident #9 to exhale prior to inhalation. Interview with Resident #9 on 06/16/15 at 3:41 PM revealed he forgot to exhale prior to inhalation and would prefer a reminder to exhale. Interview with the interim Director of Nursing on 06/16/15 at 9:22 AM revealed she expected staff to instruct residents to exhale prior to administration of inhalant medication. 2. Resident #10 was admitted to the facility on 05/29/13 with diagnoses which included hypertension. Review of a nurse practitioner's (NP) order dated 03/31/15 revealed direction to decrease the dose of Resident #10's blood pressure medication, metoprolol, to 12.5 milligrams (mg.) twice daily. The NP progress note dated 03/31/15 recorded a low blood pressure measurement of 99/58 which required a decrease of the dose. Observation of Nurse #2 on 06/16/15 at 8:20 AM revealed she measured Resident #10's blood pressure. Nurse #2 reported Resident #10's blood pressure measured 124/44 millimeters of mercury (mmHg.). Nurse #2 crushed the metoprolol 12.5 mg. and began to enter Resident #10's room at 8:31 AM. The surveyor stopped Nurse #2's administration of the metoprolol. Interview with Nurse #2 on 06/16/15 at 8:32 AM revealed she intended to administer the medication then recheck the blood pressure later	F 332	100/50 and the physician be notified. 3. New hires will be educated on administering orally inhaled medications and blood pressure guidelines for a blood pressure less than 100/50 (holding medication and physician notification). Unit Manager or DON will perform 3 random med pass observations a week for 4 weeks, then 2 random med pass observations bi-weekly for 4 weeks, then 2 random med pass observations quarterly for 2 quarters. The observations will be analyzed during risk meetings. 4. Med pass observations and analysis will be reviewed in the QA/QI committee meetings and revised as needed monthly.	

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F 332	Continued From page 2	F 332		

in the morning. Nurse #2 explained there were no parameters to guide administration of the metoprolol ordered by the physician. Nurse #2 explained she began employment at the facility last week and would check with the nursing unit manager for guidance.

Observation on 06/16/15 at 8:33 AM revealed the nursing unit manager directed Nurse #2 to recheck Resident #10's blood pressure.

Observation on 06/16/15 at 8:41 AM revealed Nurse #2 measured Resident #10's blood pressure and reported the blood pressure measured 84/42 mmHg. Nurse #2 rechecked Resident #10's blood pressure at 8:44 AM and reported a measurement of 85/45 mmHg. Nurse #2 explained she would obtain another blood pressure monitor which would be more accurate than the battery operated wrist cuff.

Observation on 06/16/15 at 8:47 AM revealed Nurse #2 measured Resident #10's blood pressure with a different machine. Nurse #2 reported Resident #10's blood pressure measured 82/56 mmHg. Nurse #2 reported she would not administer the blood pressure medication, metoprolol.

Interview with the interim Director of Nursing (DON) on 06/16/15 at 9:25 AM revealed she expected nurses to follow the facility's unwritten policy and hold blood pressure medication if the systolic blood pressure measured below 110 or the diastolic below 60 mmHg.

Telephone interview with the NP on 06/16/15 at 2:30 PM revealed she expected staff to recheck a blood pressure which measured 124/44 mmHg

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F 332	Continued From page 3 prior to administration of the medication since blood pressure machines could vary in accuracy. Telephone interview with the physician on 06/16/15 at 2:42 PM revealed Resident #10 would not be harmed if the nurse continued to give the metoprolol with a low diastolic measurement but would want it held when the systolic measured below 100 mmHg. The physician explained he would expect the nurse to recheck the blood pressure with a different machine prior to administration.	F 332		