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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING ______ B. WING ______	C 08/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 000	INITIAL COMMENTS Survey team exited facility on 8/13/15. Pertinent staff interviews were conducted offsite 8/17/15.	F 000		
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 record review, staff and family interview and review of home health agency documentation, the facility administered two (2) patches of fentanyl (a narcotic analgesic) 100 micrograms (mcg) per hour in error for 1 of 1 sampled residents (Resident #1) receiving fentanyl patches. The findings included: Resident #1 was admitted to the facility on 7/23/15. Diagnoses included status post amputation, sacral abscess, right chest wall wound, history of gout, history of degenerative disk disease, lumbar radiculopathy and inflammatory arthritis. Physician orders dated 7/23/15 included Duragesic (brand name of fentanyl) - 50 Patch: apply 2 patches transdermally every 72 hours for pain control. Review of the July Medication Administration Record (MAR) revealed the Duragesic was given on 7/24/15, 7/27/15 and 7/30/15. The narcotic sign out records revealed on both 7/24/15 and 7/27/15 four (4) fentanyl 25 mcg patches were removed from the facility back-up supply by the nurse who administered the patches.	F 333	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F333 Corrective Action for Resident Affected Resident #1 was discharged from the facility on 7/31/15. The nurse that made the medication error on 7/30/15 was educated by Director of Nursing and Unit	9/14/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2015

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 333	Continued From page 1 A Narcotic Count Sheet dated 7/27/15 indicated the pharmacy had supplied one (1) box of ten (10) fentanyl 100 mcg/hour patches for Resident #1. The label on the sheet included Resident #1 ' s name and read " Apply 1 patch to skin every 72 hours (every 3 days). " The form included columns for the nurse to record the date and time given, how many were on hand, the amount given, the nurse ' s signature and the amount remaining. The only entry on the form was dated 7/30/15 at 8:00 AM and indicated 10 patches were on hand, 2 were given and 8 remained. Resident #1 was discharged from the facility on 7/31/15. During an interview on 8/11/15 at 4:21 PM, Resident #1 ' s family member stated she observed the resident to be sleepier on 7/31/15 and 8/1/15. The family member indicated a home health nurse had visited on 8/1/15 as scheduled. After the nurse left the family member noticed 2 fentanyl 100 mcg/hour patches on his left arm. The family member said she called the home health agency immediately and told the nurse who had visited earlier that day. The family member indicated the nurse called the physician who instructed to remove the patches and observe for respiratory problems. If none, may replace on 8/2/15. During the interview the family member revealed a clear sandwich type plast bag containing 2 fentanyl 100 mcg/hour patches which she stated she removed from the resident on 8/1/15. Handwritten on each patch was " 7/30/15 " " 8 A " and illegible initials very similar to the initials dated 7/30/15 on the Narcotic Count Sheet. The nurse from the home health agency was not available for an interview during the survey. The home health agency did provide a copy of the notes from 8/1/15. The notes indicated the nurse	F 333	Manager and disciplinary action issued for the med error on 8/18/15 and suspended for 1 day. Corrective Action for Resident Potentially Affected All residents with Duragesic patches have the potential to be affected by this alleged deficient practice. All Residents with Duragesic patches were reviewed by the Director of Nursing on 8/18/15 to ensure that the correct strength were present on the EMAR, signed out correctly and the patches were correct on those residents. The results of this audit was that residents with Duragesic patch order was correct and patches on resident were correct and compliant with medication orders by physician. Education was provided to all nurses that the medication pass is complicated and has the potential to produce most medications errors. The 10 rights of medication pass was taught for administering medications to residents under effective and safe circumstances (see below). Systemic Changes Orders for Duragesic patches will be reviewed in the Daily QA meeting Monday through Friday to ensure that orders are written correctly, clearly and reflects the strength the pharmacy has supplied. An education packet was provided for all nurses for How to Prevent Medication Errors with an example of Duragesic Patch. It included a definition of	

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F 333	Continued From page 2 had visited Resident #1 on 8/1/15 and that a family member called to report the resident had 2 fentanyl patches on. The note also revealed the nurse notified the physician that the resident had 2 patches on, and the physician " states OK to remove and then replace tomorrow if sedation is not present. Monitor respirations and go to ED (emergency department) if respiratory compromise is noted. Called (family member) and rechecked on patient who states he is still drowsy but breathing fine. " During an interview on 8/13/15 at 12:12 PM, Nurse #1 stated she had administered Resident #1 ' s medications on 7/30/15. The nurse then reviewed the MAR and the Narcotic Count Sheet. Nurse #1 said it was very hectic and day and she could have mistakenly given Resident #1 two (2) 100 mcg/hour fentanyl patches and not noticed that the actual dose specified on the MAR was for 100 mcg/hour. During an interview on 8/13/15 at 4:00 PM, the Director of Nursing stated she expected nurses to administer drugs as ordered by the physician.	F 333	medication errors, Medication Error Quality Initiative and identified the most frequent medication errors, the ten rights of medication administration and transdermal patch application procedures. An example of Duragesic patches was given with drug information, side effects to watch for and to notify MD and DON for any medication error. Also an in-service was conducted on 8/28/15 by the DON and Unit Managers. Those who attended all RNs, LPNs, and CNAs, FT, PT, and PRN. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included again How to Prevent Medication Errors with an example of Duragesic Patch. It included a definition of medication errors, Medication Error Quality Initiative and identified the most frequent medication errors, the ten rights of medication administration and transdermal patch application procedures. An example of Duragesic patches was given with drug information, side effects to watch for and to notify MD and DON for any medication error. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or Unit Manager will monitor this issue using the "Survey	

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F 333	Continued From page 3	F 333	QA Tool for Preventing Duragesic Patch Errors ". The monitoring will include verifying that Duragesic patch orders are correct, clear and reflects the strength supplied by pharmacy and to ensure that the correct strength is present on the EMAR, signed out correctly and the patches on the resident is correct for those residents. All residents with orders for Duragesic patches will be reviewed. This will be done daily Monday thru Friday the DON and Unit Managers and weekends the Weekend Supervisor or Charge Nurse for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		9/14/15

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F 425	Continued From page 4 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and pharmacy technician interview, the facility failed to order and have available medications as ordered for 1 of 3 sampled residents (Resident #2). The findings included: Resident #2 was admitted to the facility on 7/27/15 at 6:30 PM. Diagnoses included status post hip replacement, glaucoma and hypertension. Physician orders on admission included baclofen (a skeletal muscle relaxant) 10 milligrams (mg) by mouth three times a day, Maxzide-25 (an antihypertensive agent) by mouth daily, and Timolol Maleate (an eye medication for glaucoma) Gel Forming solution 0.5% 1 drop into each eye daily. The July Medication Administration Record revealed Resident #2 received most of his scheduled medications at 8:00 AM on 7/28/15. The baclofen was scheduled to be given at 8:00 AM, 2:00 PM and 8:00 PM; the resident only received the 8:00 PM dose. The Maxzide and Timolol were scheduled to be given at 8:00 AM but were not given until 7/29/15. During a telephone interview on 8/12/15 at 11:15	F 425	Corrective Action for Resident Affected: Resident#2: Ordered medication was provided and obtained from pharmacy and administered on 7/29/2015. Medication error reports were completed for missing medications for resident #2 on 7/28/2015. Nurse responsible for admission medication availability was counseled and educated about obtaining medications for new residents from pharmacy, Pixis or back up pharmacy to provide the medications as ordered by the physician. This counseling was done by the Director of Nursing on 8/17/15. Corrective Action for Resident Potentially Affected: Residents have the potential to be affected by this alleged practice. On 8/18/2015 an audit was conducted by DON of the EMAR notes for the past 3 weeks to ensure residents medication were available to be given per MD order.	

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F 425	Continued From page 5 AM the pharmacy technician indicated the pharmacy received orders for Resident #2 on 7/28/15 and filled the order. The pharmacy technician said there was no record that medications were needed from the back-up pharmacy for Resident #2. During an interview on 8/13/15 at 11:06 AM, the Director of Nursing explained that orders have to be received by the pharmacy by 3:00 PM at the latest for delivery the same evening. If a resident is admitted later in the afternoon or evening, then medications would need to be obtained from the facility back-up drug supply (Pyxis) or from the back-up pharmacy. The facility must contact the pharmacy when drugs are needed from the back-up pharmacy; the pharmacy then contacts the back-up pharmacy to order delivery to the facility. During an interview on 8/13/15 at 12:54 PM, the Nursing Supervisor stated they had to get new medication orders faxed to the pharmacy by 3:00 PM to assure delivery that evening. If orders come in later, the nurse is expected to call the pharmacy to request the drugs from back-up. During an interview on 8/13/15 at 2:35 PM, Nurse #2 said she was the nurse for Resident #2 on 7/28/15 during the day shift. The nurse indicated if a medication was not available she would notify the pharmacy so back-up delivery could be arranged. The nurse stated the drugs she gave to Resident #2 on 7/28/15 were available in stock, the Pyxis or borrowed from other residents. She said she did not recall getting a delivery from the back-up pharmacy that day but thought she had called the pharmacy to request the drugs.	F 425	Any medication that was not available for administration, the nurse was contacted for correction and counseling. There were no medications found as not available for administration on 8/18/2015. Systemic Changes: All new admissions will be reviewed in the Daily QA meeting on Monday through Friday to review medications and check with the nurse on the hall to ensure all medications have been received for the residents. On weekends the DON or Unit Manager if DON is unavailable, will call the facility to ensure that medications have been received for new admissions on Friday, and Saturday. An education packet was provided for the nurses, FT, PT and PRN, for Ensuring that Medications are not Missed Due to Availability. Also an mandatory in-service was conducted on 8/28/2015 by DON and Unit Managers. Any nurse who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included Ensuring Medications are not missed due to availability, including how to order medications from the pharmacy, ensuring that medications are available as ordered by the physician by back-up pharmacy and the use of the Pixis machine if not received from the pharmacy and notifying the DON of any unavailable meds. Monday through Friday the Daily Clinical meeting will review the EMAR progress notes of the previous day or days to	

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F 425	Continued From page 6	F 425	include weekend and holidays. Instances will be identified of medications documented as not available to be given. Once medications are identified as not available for administration, immediate action will be taken to obtain the drug and counsel the nurse as indicated. The Daily Clinical meeting includes the DON, Unit Managers, MDS, Medical Records, Dietary and other clinical staff as needed. Quality Assurance: To ensure compliance the DON and/or Unit Managers in her absence, will conduct a review using the EMAR progress notes printed off to review with nurses any resident identified without meds available from the pharmacy. Action will be taken as outlined above. This will be done daily Monday through Friday for three months in our daily Clinical meeting. Compliance will be monitored and ongoing auditing program reviewed at the Quality Assurance meeting. Med availability will be added to the Quality of Life list to be reviewed by the Quality Assurance committee to check off weekly. The Quality Assurance meeting is attended by the DON, Unit Managers, MDS Coordinator, Medical Records, Dietary Manager and the Administrator. Results of the audit will then be shared in the Quarterly Quality Assurance Meeting with the Medical Director with verification of his attendance along with members of the QA team and Department Heads.	