STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 WINSTEAD AVENUE ROCKY MOUNT, NC 27804

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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 and staff interviews, the facility did not monitor PRN (as needed) pain medications (Oxycodone) to ensure that the narcotic pain medication was kept in-house for 1 of 1 discharged residents (Resident #1) who was requesting PRN pain medications. Findings included: Resident #1 was admitted to the facility on 12/16/15 and discharged to the hospital on 12/20/15 for evaluation. Cumulative diagnoses included chronic back pain with a history of multiple back surgeries, hypertension and diabetes mellitus. An admission note of 12/16/15 at 11:30 AM indicated Resident #1 was admitted with complaints of chronic back pain due to a history of 3 back surgeries. He had limited range of motion to his lower extremities due to chronic pain. A physician's order of 12/16/15 noted that Oxycodone 5 milligrams could be given every 4 hours as needed for moderate pain. Another physician's order noted that 1 - 2 tablets of Oxycodone 5 milligrams (a form of Oxycontin used to treat chronic pain) could be given every 4 hours as needed for severe pain. Resident #1 also received scheduled doses of Oxycontin ER (extended release) 20 milligrams twice daily (a	F 333	Complaint Investigation January 12-14, 2016 F 333 D 1 .Resident # 1 was not a resident residing at the facility at the time of the complaint investigation. 2. Current residents that are currently ordered PRN pain medications were reviewed and none were found to be affected. Completion 1/14/16 3. Current licensed nurses will be in-serviced on the proper procedure for re-ordering medications. Completion 1/29/15 Weekly random audit will be completed by the DON or designee to ensure PRN medications are ordered and received timely. 1/14/16 and ongoing 4. The DON or designee will present these audits to the QA Committee monthly for 3 months to ensure ongoing substantial compliance.	2/11/16

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

Electronically Signed | 01/28/2016

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narcotic pain medication used to treat moderate to severe chronic pain in an extended release form).

The December 2015 physician's orders noted that Resident #1 was also receiving Baclofen (a muscle relaxer and anti-spastic medication used to treat muscle spasms) 20 milligrams 4 times daily and Gabapentin ((an anti-epileptic medication which affects chemicals and nerves in the body that are involved in some types of pain) 600 milligrams 3 times daily.

Resident #1's care plan of 12/16/15 identified that Resident #1 was at risk for pain related to his history of chronic back pain. Interventions included administration of pain medications as ordered.

A health status note of 12/17/15 at 4:27 AM noted the PRN (as needed) pain medication was given at 3:00 AM.

A physician's progress note of 12/17/15 at 1:35 PM indicated Resident #1 had chronic pain which was managed with Oxycontin, Baclofen, Oxycodone, and Neurontin.

A health status note of 12/17/15 at 2:52 PM noted Resident #1 had complained of chronic back pain and had received Oxycodone PRN (as needed) twice on this shift and the medication was effective.

A health status note of 12/18/15 at 6:28 AM indicated Resident #1 had requested pain medications twice and was requesting them every 4 hours.

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According to the controlled medication utilization record for Resident #1 for Oxycodone 5 milligrams, Resident #1 had requested and was given 2 tablets of Oxycodone 5 milligrams on 12/19/15 at 12:00 Midnight with 10 tablets remaining in stock. Resident #1 received 2 tablets of Oxycodone 5 milligrams at 5:00 AM on 12/19/15 with 8 tablets remaining. Nurse #4 administered 2 tablets of Oxycodone 5 milligrams to Resident #1 at 9:15 AM on 12/19/15 with 6 tablets remaining. Nurse #4 administered 2 tablets of Oxycodone 5 milligrams to Resident #1 at 1:15 PM on 12/19/15 with 4 tablets remaining. 2 tablets were administered to Resident #1 by Nurse #3 at 5:00 PM with 2 tablets remaining on 12/19/15. Nurse #3 administered the last 2 tablets to Resident #1 at 9:00 PM on 12/19/15.

The admission Minimum Data Set (MDS) assessment of 12/20/15 noted Resident #1 was independent in decision making. He required extensive assistance from staff for activities of daily living. It was noted that he received scheduled as well as PRN (as needed) pain medications. His pain was not assessed on this document.

A health status note of 12/20/15 at 2:37 AM by Nurse #1 indicated that Resident #1's PRN (as needed) medication Oxycodone was not available. It was noted that Nurse #1 had telephoned the on-call pharmacy and was told a hard copy script was required to fill the Oxycodone. Nurse #1 telephoned the on-call physician. It was noted that the pharmacy had received the prescription and she was waiting for delivery of the medication.

A health status note of 12/20/15 at 4:15 AM by

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Nurse #1 indicated she had reassured Resident #1 that the medication was on the way.

Another health status note by Nurse #1 of 12/20/15 at 6:48 AM indicated that Resident #1 was alert and oriented and in no distress. It was noted that he had been medicated with Oxycodone 10 milligrams for back pain that he rated as 10/10 (pain scale) upon pharmacy arrival.

A telephone interview was conducted with Nurse #1 on 01/14/16 at 2:10 PM. She stated Resident #1 had asked for his PRN pain medication and she realized there were no more Oxycodone tablets in stock. She stated she telephoned the pharmacy and was told a hard script was required in order to fill the medication. Nurse #1 stated she telephoned the on-call physician and reported the issue and the physician took care of the problem. She commented that she had offered other medications to Resident #1 but he told her those medications were not effective or he was allergic. She couldn't remember which medications she had offered. Nurse #1 stated he was upset that he couldn't get his Oxycodone. Nurse #1 stated that the nurse who administered the last few doses of the Oxycodone should have ordered it. She stated she was not told by the off-going nurse (Nurse #3) that there were no more Oxycodone tablets. She did confirm that narcotics had been counted at the beginning of the shift. Nurse #1 reported that the day shift nurse (Nurse #4) should have made sure the medication was in the building before leaving that day.

Nurse #4 was interviewed on 01/14/16 at 2:30 PM. She stated she remembered Resident #1

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because of his pain issues. She stated he took narcotics for pain control. She remembered the incident with the medication but wasn't sure of the exact date. Nurse #4 stated when the nurses counted the narcotics they knew how many pills were on hand for each narcotic. She stated in order to get medications from the pharmacy the sticker should be removed from the medication card and faxed to the pharmacy when the number on hand got low. Nurse #4 stated if the on-hand amount was down to 8 or 10 tablets the nurse should re-order. Nurse #4 stated she didn't notice the number of pills was low until after the 12:00 PM cut off time for ordering from the pharmacy. She stated she telephoned the pharmacy instead of faxing the request. Nurse #4 reported that she did not remember what time she had telephoned the pharmacy nor did she remember who she had spoken to as she did not make any nurse notes about the incident. She commented that she was told that there was a refill left for the Oxycodone and no hard script was needed. She also commented that she was told the medication would be in the facility with the 6:00 PM delivery from the pharmacy. Nurse #4 was not sure whether she had reported it to the on-coming nurse (Nurse #3) or not.

A telephone interview was conducted with Nurse #3 on 01/14/16 at 5:00 PM. She stated she had counted medications which included narcotics that day (12/19/15) with the off-going nurse (Nurse #4) but didn't notice that there was a low number of Oxycodone tablets on hand. She also stated medications were counted with the on-coming nurse (Nurse #1) that night but she didn't realize he was out of Oxycodone. Nurse #3 stated Resident #1 was receiving a scheduled pain medication Oxycontin and he had a lot of

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back pain. She reported that Resident #1 did routinely request PRN Oxycodone in between the scheduled Oxycontin medication. She stated she did not call the pharmacy because she thought the issue with the Oxycodone had been handled before she came to work that night and that the medication had been ordered. When questioned if Nurse #4 had reported to her that the Oxycodone was going to run out, she responded she didn't remember if she did or not. She also stated she thought the medication was in the back-up box in the facility. Nurse #3 commented that the issue should have been taken care of by day shift before she came to work that night on second shift.

A health status note of 12/20/15 at 9:26 PM by Nurse #2 noted that Resident #1 had complained of pain and reported that he had no pain relief from the medications. Nurse #2 noted that he complained of leg pain and slight back pain. The on-call physician was notified and orders were given to send Resident #1 out for evaluation.

Nurse #2 was interviewed on 01/14/16 at 3:35 PM. He stated he remembered Resident #1 and there had been an incident regarding pain. He reported that Resident #1 had a long history of chronic pain. He reported he had received a telephone call from a family member reporting that Resident #1 was in pain. Nurse #2 stated he went down to Resident #1's room to assess him and was told by Resident #1 that the pain medication was not relieving his pain. Nurse #2 stated he notified the on-call physician and received orders to send him out for evaluation. He commented pain medication had been administered that night (12/20/15) before he was sent out.

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A telephone interview was conducted with a pharmacist with the facility's pharmacy on 01/14/16 at 4:00 PM. She stated Oxycodone 5 milligrams had been dispensed on 2 occasions for Resident #1. She stated they dispensed 30 tablets on 12/15/15 and 30 tablets on 12/20/15 from the back up pharmacy. The pharmacist stated that she was viewing his medications on her computer and it was clearly noted that there were no refills for the Oxycodone and all of the tablets on the original script of 12/15/15 had been dispensed. She commented that there was no pharmacist in the pharmacy that would have told Nurse #4 that a hard script was not needed nor would they have told her that there were refills remaining. The pharmacist stated there was a note that a verbal order had been received at 2:31 AM for the 30 tablets that were dispensed on 12/20/15. The pharmacist stated the nurse (Nurse #4) should had faxed the request to the pharmacy and she would have been informed via a return fax that the pharmacy needed a hard script to fill the request. She reported that there was no reason for the facility to run out of Oxycodone as it was clearly marked on the medication cards sent to the facility when they were dispensed that there were no refills. She also reported that the nurse could have faxed the request and she did not. She stated the nurse could have looked at the label on the medication and would have seen there were no refills. The pharmacist stated she felt that Nurse #4 had gotten the medication request confused with another resident's medication as she had no record of any telephone requests on 12/19/15 for Oxycodone 5 milligrams for Resident #1.

The Director of Nurses (DON) was interviewed on

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01/14/16 at 5:30 PM. She stated she had been in the DON position for only a short while and wasn't sure what the previous DON had done about the issue with the pain medication for Resident #1. She stated narcotic medications were counted at the beginning of each shift as well as the end of each shift and that any one of the nurses working should have noticed Resident #1 was giving out of the Oxycodone pain medication. She stated if a resident was taking a PRN (as needed) medication regularly the nurses should be monitoring to make sure that medication was on hand. The DON stated her expectation was that pain medications would not give out and any of the nurses could have re-ordered the Oxycodone. The DON stated Oxycodone was not one of the medications that was kept in their back up medications. She added that she had reviewed the controlled medication utilization record for Resident #1's Oxycodone and felt that Nurse #4 should have been proactive in making sure the pain medication did not give out since she administered 2 doses (4 tablets) of the PRN Oxycodone on day shift on 12/19/15. The DON commented Nurse #4 should have gotten the hard script from the physician so the medication could be refilled. She also commented Nurse #4 should pass it on to the on-coming nurse if she was unable to obtain it. The DON reported the pain medication should have never given out. The DON stated that when Nurse #3 gave the last 2 tablets of Oxycodone she should have either ordered the medication or reported it to another nurse but in either case the medication should have been ordered. She commented that Resident #1 did receive the medication but it was 4 hours after he had requested it.