STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. BUILDING _____ B. WING _____	C 02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB AND HC CTR AT VILLAGE GR	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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F 332 SS=E	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, record review and staff interviews the facility failed to ensure residents were free of a medication error rate of 5% or greater as evidenced by 6 errors out of 28 opportunities for error, resulting in an error rate of 21.4% for 5 of 8 residents observed during medication pass (Residents #3, #7, #2, #6 and #5). The fndings included: 1. Resident #3 was admitted to the facility on 12/14/15 and had a diagnosis of Diabetes Mellitus. Review of the physician ' s orders revealed an order dated 12/14/15 for Accuchecks (finger stick blood sugars) AC before meals and at bedtime followed by an order to give 2units of Novolog Insulin for a finger stick blood sugar (FSBS) of 150-200. On 2/14/16 at 5:45PM, Nurse #1 was observed to check a finger stick blood sugar on Resident #3. The resident ' s meal tray was observed on the table in front of the resident and the resident stated she had completed her evening meal. While checking the resident ' s FSBS, the Nurse stated the blood sugar was scheduled for 4:00 PM but she had to send a resident out to the hospital and was late checking the resident ' s blood sugar. The nurse prepared 2 units of Novolog Insulin for a blood sugar of 162 and administered to the resident. On 2/15/16 at 3:39 PM the Director of Nursing (DON) stated in an interview the nurse should	F 332	F 332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE 1) Actions taken for Residents #3, #7, #2, #6 & #5: A. Resident #3 □ The resident□s blood sugar as checked at 5:45PM and the regular schedule for blood checks was resumed thereafter. B. Resident #7 □ The medication (Voltaren Gel) was passed the stop date, so the medication was immediately discontinued. C. Resident #2 □ Since there was not an order for the Vitamin C 500, the medication was immediately discontinued. D. Resident #6 □ The next dose of Gabapentin 300 mg was given at 8:00 PM as scheduled. E. Resident #5 □ The attending physician was called and ordered a double dose of the Cipro for the next scheduled dispensing and then resumed the regular dosage for all further dispensing. The physician also ordered for the prescribed dosage of the Senexon-S to be given at the next administration time and continue the regular dosage for all further dispensing.	3/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/04/2016

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F 332	Continued From page 1 have notified the physician that she missed the FSBS prior to the meal and see what the physician recommended. The DON stated the blood sugar was not accurate after the resident had eaten. 2. Resident #7 was admitted to the facility on 1/27/16 and had a diagnosis of Degenerative Changes with Right Knee Pain. Review of the physician ' s orders revealed an order dated 2/4/16 for Voltaren Gel 4 grams 4 times a day to the right knee for one week. Voltaren Gel is a nonsteroidal anti-inflammatory drug (NSAID) used for the relief of joint pain of osteoarthritis in the knee. On 2/14/16 at 6:05PM, Nurse #1 was observed to apply Voltaren Gel 4 grams topically to the right knee of Resident #7. On 2/15/16 at 2:00 PM, Nurse #2 was observed to pull up the order in the computer and stated there was not a stop date put in the computer for the order therefore, the medication continued to show up on the eMAR (Electronic Medication Administration Record). The Nurse stated the computer system crashed and they had to put everything on a paper MAR from 2/3/16 to 2/5/16 and when the computer was working again the order was put in the system and the nurse did not put in a stop date so the order continued to be on the eMAR. The Director of Nursing (DON) stated in an interview on 2/16/16 at 12:05 PM the pharmacy should have put in a stop date in the computer when they entered the order. A Pharmacy Staff Member stated in an interview on 2/15/16 at 3:28 PM that pharmacy staff put in new orders that were communicated electronically to the facility. The Pharmacy Staff Member stated the nurse had to go in the system	F 332	2) Actions taken for all residents due to the potential for being affected: A. The MARs and TARs for all remaining residents were matched to the physician□s orders to ensure accuracy. B. On/before 3/10/2016 all licensed nursing staff, including contracted agency staff, were in-serviced by the DON or her designee regarding: (1) Medication pass accuracy. (2) Adhering to a timely medication pass. (3) To call the physician if a medication dosage is missed. (4) The proper process to follow before accepting or rejecting an e-link order. (5) Adding start/stop dates to all accepted e-link orders. 3) Actions taken to prevent further recurrence: A. DON, or designee, will audit medication passes for timeliness and accuracy 5x week (to include weekends) for 2 weeks, followed by weekly (to include weekends) x 6 weeks. B. On/before 3/10/2016 all licensed nursing staff, including contracted agency staff, were in-serviced by the DON or her designee regarding: (6) Medication pass accuracy. (7) Adhering to a timely medication pass. (8) To call the physician if a medication dosage is missed. (9) The proper process to follow before accepting or rejecting an e-link order. (10) Adding start/stop dates to all accepted e-link orders. C. Additional AHT (electronic medical records) training as needed for licensed	

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F 332	Continued From page 2 and accept the order and had to enter the start and stop date of the medication. 3. Resident #2 was admitted to the facility on 1/21/16 and had a diagnosis of Pneumonia. On 2/14/16 at 6:40 PM, Nurse #1 was observed to prepare and administer medications to Resident #2. The Nurse was observed to administer Vitamin C 500 mg (milligrams) to Resident #2 per order on the eMAR (Electronic Medication Administration Record). Review of the physician ' s orders for Resident #2 revealed there was not an order for Vitamin C. On 2/15/16 at 9:05AM the Director of Nursing (DON) stated Resident #2 did not have an order for Vitamin C and the order was entered by mistake in the eMAR (Electronic Medication Administration Record) for Resident #2. 4. Resident #6 was admitted to the facility on 2/12/16 and had a diagnosis of Back Pain. Review of the physician ' s orders revealed an order dated 2/12/16 for Gabapentin 300mg three times a day. Gabapentin affects chemicals and nerves in the body that are involved in the cause of some types of pain. On 2/14/16 at 7:30 PM, Nurse #1 was observed during a medication pass. The Nurse stated the resident ' s Gabapentin was due at 2:00 PM and she did not give the medication and it was too late to give the Gabapentin because the next dose was due at 8:00 PM. The Nurse stated by the time she got to the 2:00 PM medications around 4:00 PM she had to send a resident out to the hospital and did not administer Resident #6 ' s Gabapentin which was scheduled to be administered at 2:00 PM. On 2/16/16 at 12:05 PM the Director of Nursing stated in an interview she would have expected Nurse #1 to ask for help from another nurse if	F 332	staff. D. Administrative nursing staff to review all orders for all new admits or readmits during the morning clinical meeting for accurate and complete entry into AHT (MAR). 4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee: A. DON, designee, will bring results of audits to morning administrative team meeting for review, weekly X 8 weeks. B. Results of medication pass audits will be brought to the facility QAA meeting by the DON, designee, and reviewed by the QAA committee monthly X 4 months, quarterly X 2 quarters, and as needed. C. Any non-compliance with established plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised. D. Discussion, interventions, and/or revisions to established plan will be included in the meeting minutes. E. Any adjustment to the established plan, through revision and/or interventions for non-compliance will require re-inservicing of the applicable staff by the DON, or appropriate designee. F. Any revision to the established plan will require the monitoring to begin again at Step 4A and continue as outlined.	

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F 332	Continued From page 3	F 332		

she got behind with her medication pass.

5a. Resident #5 was admitted to the facility on 1/29/16. Review of the physician ' s orders revealed an order dated 2/11/16 for Cipro 250 mg (milligrams) twice a day for 10 days for a urinary tract infection. Cipro is an antibiotic used to treat different types of infection. The medication was scheduled for 12:00 PM and 12:00 AM.
On 2/14/16 at 7:40 PM, Nurse #1 was observed to prepare and administer medications for Resident #5. The Nurse stated she did not give the resident ' s 12:00 PM dose of Cipro because she was still passing morning medications. The nurse was observed to ask Nurse #3 to call the physician to see what he wanted to do regarding the missed dose of Cipro.
On 2/15/16 at 4:30 PM, Nurse #3 stated in an interview the physician ordered Cipro 500mg to be given for the 12:00 AM dose for a one time dose.
The Director of Nursing (DON) stated in an interview on 2/16/16 at 12:05 PM she expected Nurse #1 to give medications timely and to ask for help if she got behind with her medication pass.
5b. Resident #5 was admitted to the facility on 1/29/16. Review of the physician ' s orders revealed an order dated 1/29/16 for Senexon-S 2 tablets twice a day. Senexon-S is a medication used to prevent and treat constipation.
On 2/14/16 at 7:40 PM, Nurse #1 was observed to prepare and administer medications for Resident #5. The nurse was observed to prepare Ferrous Sulfate 325mg (milligrams) 1 tablet, Vitamin C 500mg 1 tablet and Senexon-S 1 tablet and administered to the resident.
On 2/15/16 at 4:10 PM Nurse #1 stated in an interview she gave Resident #5 one Senexon-S

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F 332	Continued From page 4 tablet. The Nurse stated she did not recall what the order was for the medication. On 2/16/16 at 12:05 PM the Director of Nursing (DON) stated in an interview that she expected the nurse to follow the physician ' s orders when administering medications.	F 332		
F 354 SS=F	. 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility ' s licensed staff schedule and staff interviews, the facility failed to schedule a Registered Nurse (RN) for eight consecutive hours a day, seven days a week for 4 of 8 weekend days reviewed (1/23/16, 1/30/16, 1/31/16 and 2/13/16). The findings included: Review of the licensed staff schedule revealed there was no RN coverage on Saturday 1/23/16, 1/30/16, 1/31/16, or 2/13/16.	F 354	F354: 483.30(b) WAIVER-RN 8 HOURS 7DAY/WK. FULL TIME DON 1) No action needed to be taken for any specific Resident. 2) No action needed to be taken for all other residents due to the potential for being affected.	3/10/16

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F 354	Continued From page 5 An interview was conducted with the Director of Nursing (DON) and the Staff Development Coordinator (SDC) on 2/16/16 at 2:34PM. The DON stated she started working at the facility 2 weeks ago and the SDC had been covering some weekends. The SDC stated the weekend supervisor who was the RN coverage for the weekend resigned and they had recently hired another weekend supervisor that would be the RN coverage for the weekend that would be starting soon. The Administrator stated in an interview on 2/16/16 at 3:08PM that they lost their DON and Clinical Care Coordinator at the same time. The Administrator stated they had tried to get a RN from agencies for weekend coverage but most of the nurses with the agencies were LPNs (Licensed Practical Nurses) and had a hard time getting a RN to staff on the weekend.	F 354	3) Actions taken to prevent further recurrence: A. An appropriate number of Register Nurse staff are employed to ensure that the facility will have the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. B. All employed registered nurses have been informed that they will be required to fill in if there is a vacancy in an 8 hour shift for required RN coverage. C. RN coverage will be noted on the daily staffing sheet for easy tracking. 4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee: A. DON, designee, will bring any RN coverage deficiencies to morning administrative team meeting for review, weekly X 8 weeks. B. Any RN coverage deficiencies will be brought to the facility QAA meeting by the DON, designee, and reviewed by the QAA committee monthly X 4 months, quarterly X 2 quarters, and as needed. C. Any non-compliance with established plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised. D. Discussion, interventions, and/or revisions to established plan will be included in the meeting minutes. E. Any adjustment to the established plan, through revision and/or interventions for non-compliance will require re-inservicing of the applicable staff by the	

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F 354	Continued From page 6	F 354	DON, or appropriate designee. F. Any revision to the established plan will require the monitoring to begin again at Step 4A and continue as outlined.	