STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. BUILDING _____ B. WING _____	C 01/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION HEALTH CENTER AT BRIGHTMORE	10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277

(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 333 SS=G	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to administer medication as ordered to 2 of 3 sampled residents. (Resident #1, Resident #2). Resident #1 had nausea, vomiting and diarrhea, and Resident #2 had an elevated blood pressure as a result of these medication admininstration failures. Findings included: 1. Resident #1 was admitted 08/24/2016 with diagnoses that included a fracture of the left femur, Diabetes, Hypertension, Cirrhosis, and Hepatitis C, enlarged prostate. The Minimum Data Set (MDS) dated 08/31/2016 assessed Resident #1 as being cognitively intact for daily decision making. Review of the Nurse Practitioner's (NP) progress note dated 09/06/2016 revealed she was asked by nursing to see Resident #1 since he had received another resident's medication in error. She documented a medication error had occurred and the resident received wrong medication. He had received miralax 17 micrograms, naproxen 220 milligrams (mg), aspirin 81mg, lidocaine patch, biscacoyl 10 mg, Coreg 6.25 mg, Cymbalta 60 mg, hydrocodone/APAP 5/325 mg. losartan 25 mg, Plavix 75 mg, and Senna 2 tabs. Further documentation review revealed the resident was aware of the medication error. Vital Signs were recorded as blood pressure 140/60, pulse 76, respirations 18, and temperature 97.2.	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 RESIDENTS FREE OF SIGNIFICANT MED ERRORS. Corrective Action: Resident #1 Discharged on 9/9/2016. Resident #2. Discharged on 12/19/2016. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On Feb. 15 – 21, 2017 a chart audit was initiated for all current residents that were admitted or readmitted to the facility in the last 30days by the Nurse Management Team (Director of Nursing, Unit Manager and Unit Support Nurse). The audit was completed by comparing the physician admission orders on the Hospital Discharge Summary to the current orders in the Electronic Medical Record to review for any errors. This audit was completed	2/21/17

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

Electronically Signed | 02/21/2017

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F 333	Continued From page 1 The medication error was found directly after receiving the medication. The resident denied any headache, vision changes, lightheadedness, nausea, vomiting, and diarrhea. He does feel sleepy. He denied pain. Reviewed the medication error report completed for this error and signed by the Director of Nursing (DON) on 09/08/16. It stated Nurse #2 was a new employee who had worked two days at the facility. Resident #1 was given the wrong medication. The nurse on duty was notified on 09/06/2016 at 10 AM and the doctor was notified. The DON and nurse on call were notified on 09/06/2016. The administrator and pharmacy were notified of the medication error on 09/06/2016. Vital signs were checked. Documentation of this was made in the nurses' notes. An interview on 01/30/2017 at 1:36 PM with the NP revealed the nurse who gave the wrong medication reported it to her immediately. I saw the resident immediately and put extras checks in place. The medicine he received was not a big deal. Two were blood pressure meds, others were stool softeners and pain meds. I saw him again the next day. The error was 09/06/2016. He was having nausea, vomiting and diarrhea. I thought that it was likely due to the medications he had had the day before. At that point I gave him meds as needed for nausea and encouraged a bland foods and fluids to drink. He was not unstable at any time. I saw him within 20 minutes of the medication error occurring. Other residents in the facility were also having nausea and vomiting so it may have been due to something other than the medications.	F 333	on 2/21/2017 Random Medication Observations of Several Staff over different shifts and units (RN's and LPN's, Full time, Part time and PRN) were completed by DON, Support Nurse, Unit Manager, and Pharmacist on Feb. 15 – 21, 2017. Eight staff were observed. The Random Medication Observations were of multiple routes of administration (oral, enteral, intravenous, subcutaneous, topical, optical etc.) and a minimum (not maximum) of 25 medication opportunities. All the resident's medication for each observed medication administration were observed and documented. One of residents were noted to have Medication errors. All the medication errors and drug reactions were immediately reported to the attending physician, Director of Nursing, Administrator and Pharmacist. Physician orders were implemented. A medication discrepancy report and/or adverse drug reaction report was completed Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) on the fact that all residents have to be free of any significant medication errors. The education focused on; Definition of Medication Error/Discrepancy, Definition of adverse Drug Reaction. What is a medication error? What is a "Significant Medication Error'? Definitions of the Types of Medication errors to include wrong patient, wrong product, wrong product	

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F 333	Continued From page 2 Durning an interview on 01/30/2016 at 2:56 PM the DON stated that Nurse #1 was on the med cart and was orienting a new nurse, Nurse #2, the day the medication error occurred. Nurse #1 gave Nurse #2 the medication she had poured to give Resident #1. Nurse #2 gave the medications to the wrong resident. An interview with the Pharmacist on 01/30/2017 at 3:16 PM revealed that the naproxen and aspirin could have potentiated or enhanced the effect of the Coumadin that Resident #1 was on. The losartan could have lowered his BP. A phone interview on 01/30/2017 at 3:43 PM with Nurse #2 revealed she had worked the day of the med error that occurred with Resident #1. She was orienting with Nurse #1. She stated there were lots of residents so Nurse #1 said she would pour the medications and Nurse #2 could give the medications to the residents. I went to the wrong room. I told the nurse. The NP was there in the building and she came and saw the resident. The NP told me to make a list of everything he got that was not his medication and the side effects. She told me to go to the resident and explain it to him. A phone interview on 01/30/2017 at 4:01 PM with Nurse #1 revealed she did not remember Resident #1 or med error that occurred on 09/06/2016 with him. An additional interview on 01/30/2017 at 4:15 PM with the NP revealed her expectation was that correct medications are given to the correct resident. She stated Resident #1 did "ok" after receiving another resident's medications since he had received only one dose. He had diarrhea one	F 333	strength, wrong form of product, expired product, dose omission, overdose /multiple dose, under dose(not including dose omission) , wrong route, wrong time, wrong technique, wrong rate of administration, wrong duration, expired order, lab work error, wrong documentation. What is "Medication error rate"? What to do when you have a Medication Error, Documentation guidelines for Medication Errors, The five rights of Medication Administration, What to do when the wrong drug is identified, What to do when a drug is not available, what to do when a drug cannot be administered. All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility to transcribe and follow Physician orders. Should concerns be identified anytime during the order entry or verification process, the Director of Nursing should be immediately notified. Should concerns be identified anytime during administration of a new order, the Director of Nursing should be immediately notified. The physician should be called for any order clarification 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers orders are located at each nurse's station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response	

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F 333	Continued From page 3 day and it resolved. An additional interview with the DON on 01/31/2017 at 1:03 PM revealed her expectation was that medications were to be administered correctly per their facility policies and procedures. 2. Resident #2 was admitted on 11/30/2016 with diagnoses that included joint replacement, hypertension, fibromyalgia, multiple myeloma, and hyperlipidemia. The MDS dated 12/07/2016 assessed she was cognitively intact for daily decision making. Review of Resident #2's physician's orders revealed that Lisinopril 20 milligrams (mg) by mouth daily for hypertension was ordered on her admission to the facility 11/30/2016. Review of the Medication Administration Record for December 2016 revealed Resident #2 had not received Lisinopril 20mg until December 14, 2016. She had not been administered 13 doses of this medication. Other medications she had received daily included Coreg (used to control blood pressure) and Lasix (a medication used to control blood pressure by reducing excess body fluid). Review of Resident #2's blood pressures 11/30/2016-12/13/2016 revealed a range of 115/58-186/108. The high blood pressure reading of 186/108 occurred once. Review of the pharmacy receipts revealed all of Resident #2's medications except Lisinopril were delivered on 11/30/2016. Review of the progress note by the NP dated	F 333	or does not call back within 30 minutes then the nurse is to contact the DON immediately for further instructions. This in service was completed by Feb. 21, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by completing 5 Random Medication Observations of Staff over different shifts and units (RN's and LPN's, Full time, Part time and PRN) weekly. The Random Medication Observations will be of multiple routes of administration (oral, enteral, intravenous, subcutaneous, topical, optical etc.) and a minimum (not maximum) of 25 medication opportunities. All the resident's medication for each observed medication administration will be observed and documented. The facility will monitor compliance by reviewing 5 residents' charts physician orders (new admissions/readmissions) weekly by reviewing and comparing the Discharge Summary to the Admission orders and current orders in the resident's eMAR/eTAR. This will be done on weekly basis for 4 weeks then monthly for 3	

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F 333	Continued From page 4 12/14/2016 revealed Resident #2 had requested to be sent and went to the hospital for hypertension. She had had a blood pressure of 186/108. The resident stated her blood pressure had been creeping up for a while. She noted headache and weakness as well during that time but no vision changes. Per the resident she had an electrocardiogram and blood work done. She was found not to have received her Lisinopril at our facility. Once she received the Lisinopril at the hospital her blood pressure normalized and she was sent back to the facility. An interview on 01/30/2016 at 1:36 PM with the NP revealed that Resident #2 went to the emergency room (ER) one night per her request for her blood pressure. She came back the same day. The NP stated she saw her the next day. Per the resident she stated the hospital found she was not on her Lisinopril and so they put her back on it. We continue what the hospital had the resident on when they are admitted. It was ordered on admission and got missed. So she was not getting her Lisinopril until she went out to the ER and they discovered it. I had ordered it for her. In the process of her admission it got missed. An interview on 01/30/2016 at 3:16 PM with the Pharmacist revealed Resident #2 had Lisinopril started on 12/14/2016 and her blood pressure was 126/84 that day. The Pharmacist also stated Resident #2 had received Coreg which helped to maintain her blood pressure. An interview on 01/30/2016 at 4:25 PM with the Physician revealed her expectation was that the provider would be notified of high or low blood pressures. She stated she expected orders to be	F 333	months by the Director of Nursing, Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _Feb. 21, 2017	

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F 333	Continued From page 5	F 333		

picked up and implemented. She said if everyone did what was expected in reviewing orders no orders would will fall through the cracks or get missed.

An interview on 01/30/2016 at 5:45 PM with Nurse #4 revealed the physician wrote the order in the system and she checked it and confirmed it. She stated she then faxed it to the pharmacy just to make sure nothing fell through the cracks. She stated for a new admission the orders were signed off by the provider if they come with orders and the supervisor put them in the system. The doctor signed off on the new orders. Most of the time the supervisor did the orders for us and we checked it and the night shift checked them.

An interview on 01/31/2017 at 8:32 AM with Nurse #5 revealed that the nurses had put the orders in the computer when she started to work there but now the doctor put them in. If the nurse was working the floor she would have checked for new orders every two hours.

An interview on 01/31/2016 at 1 PM with the Pharmacy Technician revealed there were two sets of orders received on 11/30/2016. The first set of orders was the discharge orders for Resident #2 from the hospital discharge summary. The second set was through the facility's computer system and did not have Lisinopril listed. She called the facility and spoke with the nurse at 3:30 PM to get clarification. The nurse stated she'd check and get back to the Pharmacy Technician. She did not get back to her so the medication was not filled. She stated the medication was in the building for use if needed. She stated no one at the facility picked up on that until 12/13/2016. It was filled and sent on

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F 333	Continued From page 6 12/13/2016 by the pharmacy for Resident #2. An interview on 01/31/2017 at 1:03 PM with the DON revealed that the process for orders was they were received on admission from the hospital discharge summary. They were reviewed by the provider and then faxed to the pharmacy. The unit manager or supervisor put the orders in the computer system and the next check was the nurse on the hall who confirmed the orders by checking the discharge summary against what went on the MAR. They made changes or clarified orders if needed. She and the unit managers look at all meds every morning. She stated her expectation was that all order transcription was accurate.	F 333		