STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345203	A. BUILDING _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BANNER ELK	185 NORWOOD HOLLOW ROAD BANNER ELK, NC 28604

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to prevent a significant medication error when a finger stick blood sugar was incorrectly obtained from a resident and the resident was given another resident's long acting insulin for 1 of 3 sampled residents to assure facility was free of significant medication errors (Resident #2). Findings included: Resident #2 was admitted to the facility on 01/23/18 with diagnoses which included high blood pressure, anxiety, seizures, low thyroid hormones and paralysis. A review of a physician's admission order dated 01/23/18 indicated there were no medication orders for insulin. A review of a physician's order dated 01/23/18 indicated to obtain blood sugar checks every 4 hours for 24 hours and notify physician of any blood sugars less than 60 and the indication was due to a medication error. A review of a written statement dated 01/23/18 at 10:15 PM by Nurse #2 revealed Nurse #1 was administering medications to Resident #2. The document indicated Nurse #2 was assisting Resident #2's roommate when Nurse #1 reported she had made a medication error when she	F 760	1. What action(s) were taken immediately for the affected resident(s)? Resident #2 was immediately assessed, the physician was notified and orders received to monitor blood sugar every 4 hours x 24 hours and report less than 60mg/dl. Resident blood sugars never were less than 130mg/dl. Name alert stickers were placed on Resident #1 and #2□'s medication administration records and medication cards. 2. What actions were taken to ensure safety of all residents? The Director of Nursing audited 100% of facility residents to identify similar first and/or last names, no other residents were identified at the time of audit. Medication carts were audited for proper labeling of medications. 3. What Measures or systemic changes will be made to ensure that the deficient practice will occur in the future? Nurse #1 completed the corporate online training titled Rights of Medication Administration and completed her Medication Pass Observation on 1/25/18. Facility nursing staff completed the online training Rights of Medication Administration and Medication Pass Observation by 2/9/18. Any PRN staff or	2/19/18

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

Electronically Signed | 02/15/2018

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F 760	Continued From page 1 checked Resident #2's blood sugar and the result was 279 and Nurse #1 had given Resident #2 Lantus insulin (a long acting insulin). A review of a written statement dated 01/23/18 at 11:00 PM by Nurse #1 revealed when she was administering bedtime medications, she made a medication error when she obtained a blood sugar level and gave Resident #2 Lantus insulin 25 units on 01/23/18 at 10:15 PM. The statement indicated Resident #2's roommate had orders for the blood sugar check and scheduled insulin and Resident #2 and her roommate had similar first names. The statement revealed the physician was notified of the medication error and orders were received to check blood sugars every 4 hours for 24 hours and notify the physician for blood sugars less than 60. The statement further revealed Nursing Management and Resident #2 were informed of the medication error. A review of nurse's progress notes dated 01/24/18 at 1:06 AM indicated Nurse #1 was administering medications at approximately 10:15 PM on 01/23/18 when she mistakenly obtained a blood sugar level and gave 25 units of Lantus insulin to Resident #2. The notes revealed Resident #2's blood sugar was 279 prior to the insulin injection. The notes also revealed Resident #2 shared a room with a roommate who was ordered Lantus insulin and they had similar first names. The notes indicated Nurse #1 notified Resident #2's physician and received physician's orders to check blood sugar levels every 4 hours for 24 hours and notify physician of any blood sugars less than 60. The notes indicated Nurse #1 notified Nursing Management and Resident #2 of the medication error and vital signs were within normal limits and there were no	F 760	any staff on leave are not allowed to work until the aforementioned is completed. The Interdisciplinary Team Leaders will audit all new admissions during Grand Rounds to ensure any look alike names have the name alert stickers on medication administration record and medication cards accordingly on-going as part of the normal protocol. Medication carts were audited by nursing administration to ascertain medications are labeled with resident names with 100% compliance. 4. What system changes were made/modified and implemented to ensure enhanced system compliance and how will the facility monitor for sustained compliance? Nurses will be required to complete Rights of Medication Administration training on hire and annually. Nursing administration will complete medication cart audits to include proper labeling of medications and look alike names of residents for name alert stickers 5x/week on-going. Medication observation will be completed on minimum of 2 nurses weekly for 4 weeks, then 4 nurses monthly for 8 weeks, and on-going annually by nursing administration. Results of the medication pass	

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F 760	Continued From page 2 signs or symptoms of low blood sugar but continue to monitor. A review of nurse's progress notes dated 01/24/18 at 4:35 PM by the Director of Nursing (DON) indicated an interdisciplinary team meeting was conducted that morning to discuss an incident when Resident #2 received a dose of 25 units of insulin but had no physician's order for insulin. The notes revealed Nurse #1 had accidentally checked Resident #2's blood sugar and it was 279 so she administered insulin that was meant for her roommate. The notes further revealed Nurse #1 called the physician and received orders to check Resident #2's blood sugar every 4 hours for 24 hours. The notes also revealed Resident #2 had not had any issues from receiving the medication and her blood sugars had not been under 130. The notes indicated the DON checked on Resident #2 and she was alert and oriented and Resident #2 stated she was fine and wanted to go home. The notes further indicated name alerts were placed on Resident #2's Medication Administration Record (MAR) and Nurse #1 would be required to complete the rights of medication administration training prior to returning to work and responsible party was notified. A review of a facility document titled Incident Follow up and Recommendation Form dated and signed by the Director of Nursing on 01/31/18 indicated an incident occurred on 01/23/18 when Nurse #1 accidentally checked Resident #2's blood sugar and gave 25 units of Lantus insulin to the resident. The document revealed Resident #2's blood sugar was 279 prior to giving insulin and Resident #2 had been upset because she was not discharged to home from the hospital. A	F 760	observations and audits of the resident names will be reviewed during the monthly QAPI meeting for a minimum of 3 months or until the QAPI team members determine the practice is sustained on-going. The Director of Nursing is responsible for implementing the plan of correction with the Administrator responsible for the sustained compliance.	

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section labeled Recommendations and Actions taken revealed physician's orders were obtained to check Resident #2's blood sugar every 4 hours for 24 hours and blood sugars had been good and all were over 130. The document further revealed Nurse #1 would be required to complete rights of medication administration training prior to working again and name alert stickers were placed on Resident #2's medication administration records (MARs) and medications.

During an interview on 01/31/18 at 12:39 PM, Physician #1 who was also the Assistant Medical Director stated it was a big deal for a resident to receive insulin who did not have physician's orders for insulin. He explained the key was for the Nurse to let the practitioner know if the insulin was long acting or short acting so they could deal with the acute problem and give orders for how to address it. He stated Resident #2's blood sugar results in the 200 range was no reason to give the insulin without a physician order but it was a good thing her blood sugar was not low. He explained side effects from giving insulin could have long range effects but would depend on the type of insulin that was given. He then explained Lantus insulin was a long acting insulin and it was good that it was long acting but at the same time not good because it was long acting.

During an interview on 01/31/18 at 1:57 PM, the Director of Nursing confirmed a medication error occurred on 01/23/18 at approximately 10:00 PM when insulin was incorrectly given to Resident #2. She stated Nurse #1 had checked Resident #2's blood sugar instead of her roommate by mistake and gave Resident #2 Lantus insulin. She further stated she was not aware Nurse #2 had made any other medication errors.

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During a telephone interview on 01/31/18 at 2:08 PM, Physician #2 who was also Resident #2's physician explained he was made aware of the medication error the next day after Resident #2 had received Lantus insulin. He stated it was a significant medication error because a resident should not be given insulin who was not ordered to receive it. He stated he did not see harm or permanent harm to Resident #2 and since they had been checking her blood sugars she was now getting insulin because her blood sugars were running high.

During an interview on 01/31/18 at 2:37 PM, Resident #2 confirmed she had received insulin that she was not prescribed. She explained a nurse had incorrectly given her roommates insulin to her. She stated she did not initially question the injection because she received an injection for one of her medical conditions but it was not insulin. She explained after she received the insulin injection she did not feel bad and she had not had any side effects she was aware of from the insulin injection and Physician #2 had talked with her.

During an interview on 01/31/18 at 3:32 PM, the Staff Development Coordinator (SDC) explained she received a telephone call from Nurse #1 between 10:00 PM and 10:30 PM on 01/23/18. She further explained Nurse #1 stated she was giving medications and had checked Resident #2's blood sugar and had given her 25 units Lantus insulin but the blood sugar check and the insulin was supposed to have been given to Resident #2's roommate. The SDC stated she told Nurse #1 to call the physician on call and Nurse #1 called them and got orders to check

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blood sugars every 4 hours for 24 hours and she informed the DON and Administrator of the medication error.

During an interview on 01/31/18 at 5:25 PM, Nurse #3 who was assigned to Resident #2 stated she was made aware on 01/24/18 that Resident #2 had incorrectly received an insulin injection. She explained they monitored Resident #2's finger stick blood sugars but she had not had any signs or symptoms from receiving the insulin injection. She confirmed they had put name alert stickers on Resident #2's MARs and medications and also on her roommates MARs and medications.

During a follow up interview on 01/31/18 at 5:55 PM the DON explained it was her expectations for nurses to verify the resident's name and give the correct dosage of medication according to physician's orders. She stated she talked with Resident #2 after the medication error the next day on 01/24/18 and Resident #2 stated she was fine and had not had side effects from the medication.

During an interview on 01/31/18 at 5:58 PM the Administrator stated her expectations were the same as the DONs. She further stated it was her expectation for nurses to verify the resident's identity before they gave them medications.

During an interview on 01/31/18 at 6:08 PM, Nurse #2 stated she was helping Nurse #1 on 01/23/18. She explained she was in Resident #2's room assisting her roommate and Nurse #1 was with Resident #2. She stated Nurse #1 told her she had given Resident #2 insulin by mistake and then called the physician and Nursing

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Administration. She explained they checked Resident #2's blood sugars after she received the insulin and she did not have any signs or symptoms from the insulin injection.

During an interview on 01/31/18 at 6:19 PM, Nurse #1 explained Resident #2 had been admitted during the day shift on 01/23/18 and the resident was upset because she had not been sent home from the hospital. She stated is was a busy evening and she had gotten insulin out of the refrigerator for Resident #2's roommate but had not labeled it with the resident's name like she normally did. She stated if she had labeled the insulin with the correct resident's name she might not have made the mistake in giving insulin to Resident #2 later that evening. She explained she was in Resident #2's room after 10:00 PM and checked her blood sugar by mistake but it was 279 so she gave her 25 units of Lantus insulin subcutaneously. She stated once she gave the insulin she realized Resident #2's roommate was supposed to get the blood sugar check and insulin because she was a diabetic. She explained she informed Resident #2 she had made a mistake and had given her insulin. She stated she called the physician on call who gave her orders to check Resident #2's finger stick blood sugars every 4 hours for 24 hours and to notify the physician if her blood sugars were less than 60 or if she had any other symptoms. She explained she called the SDC who was the manager on call and informed her of the medication error and when she finished her shift after 11:00 PM Resident #2 had not had any side effects from the insulin injection.