STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345516	A. BUILDING _____ B. WING _____	C 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONOVER NURSING AND REHAB CTR	920 4TH STREET SOUTHWEST CONOVER, NC 28613

(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 A complaint investigation was conducted on 07/24/19. There were 9 allegations and they were unsubstantiated however a tag was cited as a result of the complaint investigation.	F 000		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure that a resident's drug regimen was free from unnecessary drugs for 1 of 3 residents investigated for medication errors (Resident #2).	F 757	F757 1. The unnecessary medication was discovered the following day after receiving one dose and immediately discontinued for Resident #2. New labs	8/15/19

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

Electronically Signed | 08/15/2019

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F 757	Continued From page 1 The findings included: Resident #2 was admitted to the facility on 01/22/19 and discharged from the facility on 05/05/19. Resident #2's diagnoses included: hypertension, benign prostatic hyperplasia (enlarged prostate), dementia, and depression. Review of the comprehensive Minimum Data Set (MDS) dated 01/29/19 revealed Resident #2 was severely cognitively impaired for daily decision making and required extensive assistance with activities of daily living. Review of a laboratory test dated 04/03/19 revealed Resident #2's potassium level was 3.4 which was low. The normal parameters indicated by the laboratory were 3.5-5.1. Review of a physician order dated 04/05/19 indicated to start kayexalate (used to treat high potassium levels) 15 grams (gm) by mouth daily for 3 days for hypokalemia (low potassium) written by the Physician Assistant (PA). The order was signed off by Nurse #1. Review of the Medication Administration Record (MAR) dated 04/01/19 through 04/30/19 revealed that Resident #2 received Kayexalate 15 gm on 04/05/19 from Nurse #2. Review of a physician order dated 04/06/19 indicated to obtain a basic metabolic panel (potassium level is included) and a diagnosis of hypokalemia was written by the PA. Review of a laboratory test dated 04/06/19 revealed that Resident #2's potassium level was 3.2 which was low. The normal parameter	F 757	were drawn and KDur was immediately prescribed the next day to treat low potassium level. 2. All other residents who were prescribed Kayexalate were immediately reviewed to ensure that they had the correct diagnosis. 3. The physician assistant received education regarding when to correctly prescribe Kayexalate in order to avoid unnecessary medications. 4. Director of Nursing or designee will monitor 10 random physician orders per week for 12 consecutive weeks to ensure that medications prescribed are necessary for the diagnosis. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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F 757	Continued From page 2	F 757		

indicated by the laboratory were 3.5-5.1.

Review of a physician order dated 04/06/19 indicated in part to discontinue sodium polystyrene sulfonate (Kayexalate). Give KDur (potassium) 20 milliequivalent (meq) by mouth x 3 days then recheck potassium level.

An interview was conducted with the PA on 07/24/19 at 1:56 PM. The PA indicated she had examined Resident #2 on 04/04/19 for a chronic visit and according to her note there were no issues with his potassium level. She added that in January 2019 Resident #2's potassium level was normal. The PA explained that Kayexalate was used to treat hyperkalemia (high potassium) and not hypokalemia and it was error on her part. The PA indicated she should have prescribed KDur and not Kayexalate. She stated Resident #2's potassium level on 04/06/19 was low and the staff called the on-call provider who discontinued the Kayexalate and ordered the KDur. The PA added that Resident #2 received one dose of the Kayexalate and never displayed any signs or symptoms of hypokalemia that included chest pain, shortness of breath, nausea etc. Again, the PA confirmed that it was an error on her part and she had prescribed the wrong medication and Resident #2 received one dose of Kayexalate before it was discontinued.

An attempt to speak to Nurse #1 was made on 07/24/19 at 2:37 PM and was unsuccessful.

An interview was conducted with Nurse #2 on 07/24/19 at 3:18 PM. Nurse #2 stated that she did not recall giving Resident #2 the Kayexalate but reviewed the MAR and confirmed that she administered the medication on 04/05/19 as

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F 757	Continued From page 3 ordered. She stated when she administered the medication, she did not question the order but if she would have signed the order off indicating the Kayexalate was being ordered for hypokalemia she would have questioned the PA about it. An interview was conducted with the Director of Nursing (DON) and the Administrator on 07/24/19 at 6:49 PM. The DON stated that she was aware of the medication error and indicated that the PA should have written for KDur and not Kayexalate. The DON added that when Nurse #2 was administering the Kayexalate she would not have seen the order with the diagnosis on it and it should have been caught when the order was being signed off by Nurse #1.	F 757		