STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 08/11/2020

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TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

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E 000	Initial Comments An unannounced COVID-19 Focused Survey and Complaint Investigatin Survey were conducted on 08/11/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# E54Z11.	E 000		
F 000	INITIAL COMMENTS A unannounced COVID-19 focused infection control and complaint investigation survey were conducted on 08/11/20. 3 of 47 complaint allegations were substantiated with deficiency. Event ID #E54Z11.	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	F 757		8/19/20

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

Electronically Signed | 08/19/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 757	Continued From page 1 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Nurse Practitioner (NP) interviews the facility failed to ensure that a resident's drug regimen was free from unnecessary drugs and laboratory test were collected as ordered by the NP for 1 of 4 residents (Resident #7) whose medications were reviewed. Findings included: Resident #7 was admitted to the facility on 04/06/19 and passed away on 07/31/20. Resident #7 had diagnoses of cerebrovascular accident (CVA), hemiplegia, and Alzheimer's disease. The April, May, and June 2020 physician orders revealed no order for K-DUR for Resident #7. The June 2020 Medication Administration Record (MAR) revealed a handwritten entry for K-DUR (a potassium supplement) 20 meq (milliequivalents) 2 = 40 meq po (by mouth) daily take with food. The date of the order was handwritten as 04/21/20 and the time to be dispensed was 8:00 AM. There were five sets of initials on the June 2020 MAR signifying that Resident #7 received the K-DUR 06/02/20, 06/05/20, 06/06/20, 06/07/20 and 06/10/20. The Health Status Note dated 06/11/20 at 2:13 PM and written by the previous Director of Nursing (DON), revealed Resident #7's family and physician had been made aware Resident #7 had been administered five doses of a medication without a physician's order. No adverse effects	F 757	F757 Disclaimer Tower Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding Resident #7 was not in the facility at the time. There were no negative outcomes identified for Resident #7 related to medication administration error while in the building. On 8/13/20 the DON audited all residents with new physician orders as verbal or written orders in the last 7 days. All orders	

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F 757	Continued From page 2 from the medication had been noted. The Physician's Orders dated 06/11/20 revealed the NP gave a telephone order for a CMP (comprehensive metabolic panel) and a CBC (complete blood count) to be drawn on 06/12/20. There was no mention of the medication error or of any adverse effects in the Health Status notes after 06/11/20 at 2:13 PM through 06/15/20. The order for the CMP, which was signed off by the previous DON was not collected until 06/15/20 at 8:00 AM and revealed a Potassium level of 4.1 mmol/L (millimoles per liter) which was within the normal reference range of the test. In a telephone interview on 08/05/20 at 5:22 PM the previous DON stated there was a transcription error and another resident's order was placed on Resident #7's June 2020 MAR. She was unable to remember the name of the resident who should have gotten the K-DUR. The previous DON stated that Resident #7's potassium level had been checked but she did not know why it had not been done on the date ordered. In a telephone interview on 08/06/20 at 12:25 PM Nurse #10 stated that she was the one who discovered the K-DUR handwritten order on Resident #7's June 2020 MAR and that there was no order for the medication from the physician. She indicated she informed the previous DON and the medication was discontinued. In an interview on 08/06/20 at 1:35 PM Nurse #5, Weekend Supervisor, stated that initials in the box for a medication meant the medication was	F 757	where transcribed to appropriate MAR. There were no negative findings on this audit. Licensed nurses will be in-serviced on transcribing all new orders on to the MAR as per physician orders. This will be completed on 8/19/20. All newly hired nurses will be in-serviced on transcribing new orders on to the MAR during orientation. The DON, SDC, and/or MDS nurse will audit all residents with physician orders for potassium chloride once weekly x 4 weeks, every other week x 4 weeks, then monthly for one month to ensure new orders monitoring was completed. This audit will be documented on the MAR audit tool. The monthly QI committee will review the results of the MAR audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 757	Continued From page 3	F 757		

given.

In a telephone interview on 08/07/20 at 10:17 AM Nurse #11, who was assigned to Resident #7 on 06/05/20 and 06/10/20, confirmed that she was the nurse who made the transcription error and placed the order for K-DUR on Resident #7's June 2020 MAR. Nurse #11 indicated that if a medication was on the MAR, she would give the medication and initial the box that showed she gave it. She denied that she gave Resident #7 any K-DUR even though her initials were in the box on the MAR signifying she administered the medication on 06/05/20 and 06/10/20 to Resident #7.

In a telephone interview on 08/07/20 at 12:17 PM Nurse #12, who was assigned to Resident #7 on 06/02/20, 06/06/20 and 06/07/20, stated that if the K-DUR was on the MAR, and her initials were in the box, then she gave Resident #7 the K-DUR. She indicated that she worked on different halls and did not know Resident #7 well enough to question the K-Dur.

In a telephone interview on 08/10/20 at 11:56 AM the NP stated she remembered being informed of the medication error for Resident #7 and that she had ordered laboratory tests. The NP stated that although she did not order it to be done, she would have expected Resident #7's blood pressure and heart rate to be monitored and neurological checks to be performed every shift for the 72 hours following the discovery of the medication error. The NP stated that she also remembered that the CMP was not drawn as she had ordered and that due to the delay in the lab draw, she was unsure of the true level of the serum potassium for the time in question. She

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F 757	Continued From page 4 indicated that she expected her orders to be followed and that labs be drawn timely because the results could be less accurate if they were not. The NP indicated that due to the COVID pandemic she was not able to go into the facility to exam Resident #7. In a telephone interview on 08/10/20 at 1:30 PM the Interim Director of Nursing (DON) indicated that she was not at the facility when the medication error occurred and could not speak to specifics about the error. She indicated that, in general, if a medication error was identified she would expect an investigation to be done at the time the error was discovered to include vital signs and assessments of the resident for the 72 hours to a week following the error depending on the medication. She would also expect contact with the pharmacist to check for drug interactions and allergies. The Interim DON stated that to prevent medication errors, transcription of orders needed to be done correctly and double checked by another nurse to ensure that errors were not made. She also expected that labs be drawn as ordered and not delayed.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		8/19/20

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F 761	Continued From page 5 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 2 of 2 medication carts observed (100 and 200 hall medication carts). Findings included: 1. During an observation on 08/05/20 at 5:04 PM the 100 hall medication cart was against the wall between the bathroom and the medication room. The lock on the medication cart did not appear to be engaged. No staff members were seen near the medication cart. After approximately one minute Nurse #1 walked onto the 100 hall from around the corner. She confirmed that she was the nurse responsible for the medication cart. In an interview on 08/05/20 at 5:05 PM Nurse #1 verified that the medication cart was unlocked by opening a drawer containing medications without using a key to unlock the medication cart. She	F 761	F761 On 8/5/20 medication cart #1 was locked by LPN. On 8/13/20 the facility consultant and DON audited all medication carts and storage areas to ensure all carts were locked when not in use. All medication carts were locked. On 8/13/20 an in-service was started by the facility consultant on medication storage, including locking of medication carts as per facility policy for all licensed nurses. This in-service will be complete by 8/19/20. This in-service will be included with orientation for all newly hired licensed nursing staff. The director of nursing, staff facilitator,	

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F 761	Continued From page 6 confirmed that she had left the medication cart unlocked and unattended while she was speaking to another staff member around the corner. Nurse #1 stated that medication carts should always be kept locked when unattended so that the medications could not be removed from the carts. In a telephone interview on 08/10/20 at 1:30 PM the Interim Director of Nursing (DON) stated that when a medication cart was not in use it needed to be locked for safety. 2. During a continuous observation on 08/06/20 from 2:25 PM-2:43 PM the 200 hall medication cart was against the wall between rooms 202 and 204. The lock on the medication cart did not appear to be engaged. During this time, multiple staff members walked past the unattended medication cart, including Nurse #2. When requested, Nurse #2 who was standing at the nursing station out of view of the medication cart, walked to the medication cart and confirmed he was the nurse responsible for the medication cart. In an interview on 08/06/20 at 2:43 PM Nurse #2 verified that the medication cart was unlocked by opening a drawer containing medications without using a key to unlock the medication cart. Nurse #2 stated that he had left the medication cart unlocked and unattended in error and that he should have made sure the cart was locked. He indicated that the purpose of locking the cart was to make sure that no one could remove medications from the cart. In a telephone interview on 08/10/20 at 1:30 PM the Interim Director of Nursing (DON) stated that	F 761	and/or assistant director of nursing, will audit 2 medication carts and medication storage rooms weekly for 4 weeks, every other week for 4 weeks, then monthly for one month, to ensure they are locked as per policy. This audit will be documented on the medication storage audit tool. The monthly QI committee will review the results of the medication storage audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 761	Continued From page 7 when a medication cart was not in use it needed to be locked for safety.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		8/25/20

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F 880	Continued From page 8 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of the facility's "Linen Handling" policy, the facility failed to implement their Linen Handling policy by not placing dirty linens in a bag and then placing the linens in a container for 1 of 2 resident hallways observed (200 hallway).	F 880	F880 There is an attachment with details about the root cause analysis and directed in-servicing. There were no identified residents	

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F 880	Continued From page 9 Findings included: Review of the facility Linen Handling Policy, dated 03/10/20, for soiled linens documented, "Soiled linen should be handled as little as possible and with minimum agitation to prevent microbial contamination of the air and of staff handling the linen. Soiled linen should be bagged or placed in containers at the location where it is used." On 08/05/20 from 9:35 AM to 10:55 AM visibly soiled bath towels were observed to be wadded up on a folding chair sitting on the 200 hallway between rooms 212 and 214. Multiple staff members walked past the soiled linens during the observation period and did not remove it until 10:55 AM, when it was brought to the attention of Nurse #2. In an interview conducted with Nurse #2 on 08/05/20 at 10:55 AM he stated soiled linen should not have been sitting open on a chair in the hallway. He said soiled linen was supposed to be bagged before leaving a resident room and taken directly to the soiled linen room. He took the soiled linen to the soiled linen room and counted 4 visibly soiled towels that had been left wadded up on the chair in the hallway between rooms 212 and 214. In an interview conducted with Nurse Aide #3 on 08/05/20 at 11:15 AM she stated she was assigned to work on the 200 hall. She remarked she had not noticed the dirty linens sitting on the chair in the hallway. She was taught by the facility to bag dirty linens before leaving a resident room and take it to the soiled linen room. She stated she had not left the soiled linens sitting on the chair.	F 880	effected. On 8/13/20 the DON observed 100 hall CNA for correct handling of soiled linens using the Soiled Linen Audit Tool. No negative findings. On 8/13/20 the facility consultant provided education to the director of nursing on appropriate handling of soiled linen based on the policy and procedure. This in-service will be part of the orientation for any new Director of Nursing in the facility. On 8/13/20 the director of Nursing started an in-service with nursing staff on appropriate handling of soiled linen based on the policy and procedure. This in-service will be completed by 8/19/20. All newly hired nursing staff will be in-serviced on appropriate handling of soiled linen during orientation. The Director of Nursing, Assistant director of nursing and/or Administrator will audit 3 members of staff using the Soiled Linen Audit Tool weekly x 4 weeks, every other week x 4 weeks, then monthly for one month to ensure correct handling of soiled linens has been identified. The monthly QI committee will review the results of the infection control audit form monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator	

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F 880	Continued From page 10 In an interview conducted with Nurse Aide #4 on 08/05/20 at 11:30 AM she stated she was working on the 200 hall. She said she had not placed any soiled linens on a chair in the hallway. She remarked she was working at the facility through an agency. She stated she put dirty linens in a bag before leaving a room and took the bag to the soiled linen room to place in a bin. In an interview conducted with Nurse Aide #5 on 08/05/20 at 11:50 AM she stated she was assigned to work on the 200 hall and that it was her first day at the facility. She said she put soiled linen in a bag while in the room, sat it on the floor until finished then took it to the soiled linen room. She commented she had taken all her soiled linens to the soiled linen room and had not noticed the dirty towels in the hallway. In an interview with the Director of Nursing on 08/05/20 at 3:15 PM she commented it was her first day at the facility, but was familiar with the facility policies. She knew the nurse aides were trained to bag soiled linens in a resident's room and then take it directly to the soiled linen room. She would not expect to see soiled linens sitting open on a chair in a hallway. She commented along with being a dignity issue it was also an infection control issue. She remarked any resident with cognition problems could have wrapped themself in the dirty linen not knowing what it was.	F 880	and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	