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	345471	A. BUILDING _____ B. WING _____	C 02/04/2022

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MECKLENBURG HEALTH & REHABILITATION	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

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F 000	INITIAL COMMENTS A complaint survey was conducted from 2/02/22 through 2/04/22. Event ID# UGC311. 1 of the 11 complaint allegations were substantiated resulting in deficiencies. Past-noncompliance was identified at: CFR 483.45 at tag F 760 at a scope and severity J. The tag F760 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732		2/7/22

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

Electronically Signed | 02/17/2022

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F 732	Continued From page 1 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to post complete and accurate daily nursing staff data for 13 of 13 days of data reviewed (12/21/21, 12/22/21, 12/24/21, 12/25/21, 12/28/21, 12/29/21, 12/30/21, 12/31/21, 1/5/22, 1/7/22, 1/8/22, 1/16/22 and 1/18/22). The findings included: 1a. A review of daily nurse staffing data sheets revealed the resident census was not recorded on 12/29/21 for the 7A - 7P shift or for the 7P - 7A shift. 1b. A review of daily nurse staffing data sheets for the 7A - 7P shift, revealed licensed and unlicensed nursing staff was not recorded accurately for the following days: ·12/21/21, daily nurse staffing data sheets recorded 5 nursing aides (NA) provided 60 hours of nursing care; staff assignment data recorded 6 NA ·12/22/21, daily nurse staffing data sheets recorded 1 medication aide (MA) provided 12	F 732	There were no residents affected by this practice. The staffing coordinator corrected all nursing staff sheets identified as incorrect to reflect the correct number of Licensed Staff, Certified Nursing Assistants and census on 2/7/22. There is only one area in which the daily staffing is posted. The nursing scheduler, Director of Nursing, Weekend Supervisor and Administrator were in-serviced on 2/7/22 by the Regional Nurse Manager that nursing staff data will be posted daily in the required format and must reflect the actual number of nursing staff scheduled for that day and correct census. Any changes in nursing staff must be corrected on the nursing staff posting sheet. The Scheduler, Director of Nursing, Administrator and Weekend Supervisor	

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F 732	Continued From page 2 hours of nursing care; staff assignment data recorded 0 MA ·12/24/21, daily nurse staffing data sheets recorded 4 licensed practical nurses (LPN) provided 44 hours of nursing care; staff assignment data recorded 3 LPN ·12/29/21, daily nurse staffing data sheets recorded 3 LPN provided 36 hours of nursing care; staff assignment data recorded 4 LPN ·1/5/22, daily nurse staffing data sheets recorded 6 NA provided 72 hours of nursing care; staff assignment data recorded 5 NA ·1/7/22, daily nurse staffing data sheets recorded 5 NA provided 60 hours of nursing care; staff assignment data recorded 6 NA ·1/8/22, daily nurse staffing data sheets recorded 1 MA provided 12 hours of nursing care; staff assignment data recorded 2 MA ·1/16/22, daily nurse staffing data sheets recorded 1 MA provided 5 hours of nursing care; staff assignment data recorded 0 MA 1c. A review of daily nurse staffing data sheets for the 7P - 7A shift, revealed licensed and unlicensed nursing staff was not recorded accurately for the following days: ·12/22/21, daily nurse staffing data sheets recorded 4 NA provided 48 hours of nursing care; staff assignment data recorded 5 NA ·12/25/21, daily nurse staffing data sheets recorded 6 NA provided 72 hours of nursing care; staff assignment data recorded 4 NA ·12/28/21, daily nurse staffing data sheets recorded 3 LPN provided 36 hours of nursing care; staff assignment data recorded 4 LPN -12/28/21, daily nurse staffing data sheets recorded 6 NA provided 72 hours of nursing care; staff assignment data recorded 5 NA ·12/29/21, daily nurse staffing data sheets	F 732	will be educated on the process upon hire. The Staffing Coordinator will review each nursing staffing posting sheet against the staff assignment sheets and actual hours worked report to ensure accuracy. The Administrator or designee will audit the daily staffing post daily for two weeks, then twice a week for ten weeks for accuracy. The Administrator or designee will report findings of these audits to the facility quality assurance committee monthly for three months and thereafter as directed by the committee.	

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recorded 2 LPN provided 24 hours of nursing care; staff assignment data recorded 3 LPN
·12/30/21, daily nurse staffing data sheets recorded 2 LPN provided 24 hours of nursing care; staff assignment data recorded 4 LPN
·12/30/21, daily nurse staffing data sheets recorded 6 NA provided 72 hours of nursing care; staff assignment data recorded 5 NA
·12/31/21, daily nurse staffing data sheets recorded 0 MA provided nursing care; staff assignment data recorded 1 MA
·12/31/21, daily nurse staffing data sheets recorded 5 NA provided 60 hours of nursing care; staff assignment data recorded 7 NA
·1/5/22, daily nurse staffing data sheets recorded 6 NA provided 72 hours of nursing care; staff assignment data recorded 5 NA
·1/7/22, daily nurse staffing data sheets recorded 3 LPN provided 36 hours of nursing care; staff assignment data recorded 4 LPN
·1/7/22, daily nurse staffing data sheets recorded 0 MA provided nursing care; staff assignment data recorded 1 MA
·1/8/22, daily nurse staffing data sheets recorded 4 NA provided 48 hours of nursing care; staff assignment data recorded 5 NA
·1/18/22, daily nurse staffing data sheets recorded 5 NA provided 60 hours of nursing care; staff assignment data recorded 4 NA

An interview with the scheduler occurred on 2/4/22 at 11:41 AM and revealed she recorded the nurse staffing data sheets and posted the sheets in the lobby the first thing each morning, unless she was on leave. She stated she recorded the staff assignment sheets a week in advance and updated the sheets each morning. The scheduler stated she updated the nurse staffing data sheets when there was a change in

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F 732	Continued From page 4 staffing but could not explain why nurse staffing data sheets were not accurate for 13 of the 13 days reviewed or why the census had not been recorded and posted on 12/29/21. An interview with the director of nursing (DON) occurred on 2/4/22 at 3:55 PM. The DON stated that she expected the scheduler to post accurate staffing data and to reflect the current staffing patterns per the facility's policy. The DON stated that re-education would be provided to the scheduler and any staff who assisted in posting staffing data in the scheduler's absence. An interview with the administrator on 2/4/22 at 6:14 PM revealed she expected the nurse staffing data to be accurately recorded and when posted the data should reflect the current staffing patterns in the facility.	F 732		
F 760 SS=J	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 review and interviews with staff, family, Nurse Practitioner (NP), and the Medical Director (MD), the facility failed to administer the correct medications to a resident when Nurse #1 administered medications prescribed for Resident #8 to Resident #4. Resident #4 received 5 medications which included long-acting insulin, muscle relaxer, blood pressure medication, antidepressant, and a dietary supplement/sleep aid. This resulted in Resident #4 becoming unresponsive and she had a critically low blood	F 760	Past noncompliance: no plan of correction required.	2/17/22

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pressure (BP) of 70/40 that required intravenous fluid (IVF) resuscitation upon Emergency Medical Services (EMS) arrival. Resident #4 was transferred to the Emergency Room (ER) for evaluation of altered mental status (AMS). This failure occurred for 1 of 3 sampled residents reviewed for significant medication error.

The findings included:

Resident #4 admitted to the facility on 08/18/21 from an acute hospital. Her diagnoses included encephalopathy, heart failure, hyperlipidemia, thyroid disorder, non-Alzheimer's dementia, seizure disorder, malnutrition, and respiratory failure.

The admission Minimum Data Set (MDS) assessment dated 08/25/21 assessed Resident #4 with severe impairment in cognition. She had clear speech and was coded with adequate hearing and vision. The MDS indicated Resident #4 used a wheelchair as her mobility device. Resident #4 received antipsychotic and diuretic medications daily and required one-person physical assist for locomotion on unit that occurred only once or twice during this assessment.

Review of Physician's orders for Resident #4 for September 2021 revealed the following routine medications:

Abilify 10 milligrams (mg) once daily (antipsychotic)
Atorvastatin 20 mg once daily at bedtime (cholesterol lowering agent)
Levothyroxine 50 micrograms (mcg) once daily in the morning (thyroid hormone)

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Olanzapine 15 mg once daily (antipsychotic)
Protonix 40 mg once daily (stomach acid reducer)
Torsemide 10 mg once daily (diuretic)
Vimpat 100 mg twice daily (anticonvulsant)

Review of Resident #4's medical records from 08/18/21 through 09/24/21 revealed her baseline vital signs (VS) were within normal limits as follows:
Blood pressure (BP): 90/60 to 120/80
Respiratory rate (RR): 12 to 18 breaths per minute.
Heart rate (HR): 60 to 100 beats per minute.

The facility's medication variance report dated 09/24/21 indicated Nurse #1 entered room 212A on 09/24/21 at 9:30 PM and found Resident #4 was watching television. Nurse #1 called Resident #8's name. Resident #4 answered to Resident #8's name. Nurse #1 gave Resident #4 the following medications prescribed for Resident #8:

18 units of Levemir (long-acting insulin)
1 tablet of atorvastatin 40 mg ((cholesterol lowering agent)
1 tablet of tizanidine 4 mg (muscle relaxer)
1 tablet of melatonin 5 mg (dietary supplement/sleep aid)
1 tablet of trazodone 50 mg (antidepressant)
1 tablet of carvedilol 6.25 mg (blood pressure lowering agent)

Further review of the medication variance report revealed Resident #4's blood sugar (BS) was checked and recorded once before EMS arrival, and it was 144 milligram/deciliter (mg/dl). Nurse #1 also checked Resident #4's VS which were BP 90/60, HR 68, body temperature (T) 97.6 F, and

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RR 16. The last set of VS before the EMS arrived were BP 80/58, HR 66, T 97.6 F, and RR 16.

During a phone interview with Nurse #1 on 02/03/22 at 3:12 PM, she stated Resident #4 used to reside on the 200 Hall and had been moved to the 100 Hall shortly before 09/24/21 and would wander back to 200 Hall at times. Nurse #1 recalled she was passing medications on 09/24/21 evening on the 200 Hall and when she reached the end of the Hall around 9:30 PM, Resident #4 was sitting in the bed in room 212A with pajamas on. Nurse #1 stated that she thought Resident #4 was Resident #8 when she retrieved the medications. When Nurse #1 entered room 212A, she said to Resident #4 "How are you doing today Ms. (Resident #8's name)?" Resident #4 replied she was doing good. At around 10:00 PM, Nurse #1 realized that she had given the medications prescribed for Resident #8 to Resident #4 when Nurse #2 came on the hall looking for Resident #4 and told her the resident sitting in room 212A was Resident #4. She and Nurse #2 immediately brought Resident #4 back to her room on the 100 Hall. Nurse #1 checked Resident #4's VS and bedside BS level, gave her oral fluids, and called the on-call physician and the Responsible Party (RP) while Nurse #2 called the Director of Nursing (DON). Nurse #1 could not recall the details of Resident #4's vital signs after the incident, but stated they were all within the normal limits. She added Resident #4 had never been unresponsive and was alert throughout the time until EMS arrived. Nurse #1 could not recall when the EMS arrived. Nurse #1 stated that she received a verbal in-service via phone from the DON on the night of 09/24/21 and an in-person in-service a couple days later.

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A phone interview was conducted with Nurse #2 on 02/03/22 at 9:31 PM. She stated she came from the 100 Hall looking for Resident #4 on the 200 Hall on the evening of 09/24/21 and she found Resident #4 sitting on the bed in room 212A (Resident 8's room). Nurse #2 told Nurse #1 that Resident #4 was in Resident #8's room. When Nurse #1 told Nurse #2 that she had administered Resident #8's medication to Resident #4, Nurse #2 stated she called the DON immediately and was told to instruct Nurse #1 to stay off the medication cart. Then, she checked the medication administration records to find out what medications had been administered to Resident #4 in error. She recalled Resident #4 had never become unresponsive but was lethargic before the EMS arrived.

EMS report dated 09/24/21 indicated a call was received from the facility at 11:14 PM and the EMS arrived at the facility at 11:19 PM. Upon arrival to the scene at 11:22 PM, Resident #4 was found lying semi-fowlers (between 30 to 45 degrees) in the bed unconscious and unresponsive. Initial assessment of Resident #4 revealed she had a Glasgow Coma Scale (GCS) of 3. The Glasgow Coma Scale (GCS) is used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients. The scale assesses patients according to three aspects of responsiveness: eye-opening, motor, and verbal responses. A person's GCS score could range from 3 (unresponsive) to 15 (responsive). At 11:29 PM, Resident #4's BP was 71/45 and HR was 59. IVF resuscitation with normal saline (NS) was initiated at 11:31 PM. At 11:34 PM, Resident #4's BP and HR dropped to 70/44 and 55 respectively. The BP

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was rebounded to 98/68 at 11:44 PM after administration of the bolus IVF with NS. The EMS departed the facility with Resident #4 at 11:35 PM and arrived at the hospital at 11:43 PM.

ER report dated 09/25/21 indicated Resident #4 was brought into the ER from a skilled nursing facility as she was noted to be unresponsive and apparently given the wrong medications. About one and a half hours after receiving the wrong medications, Resident #4 was found unresponsive, bradycardic (pulse lower than 60 beats per minute), and hypotensive (BP lower than 90/60). Upon EMS arrival to the facility, Resident #4 was noted to have a GCS of 3-4, BP 70/40, and HR in the low 50s. Upon arrival to ER, Resident #4's BS at 11:57 PM was 91 mg/dl. IVF resuscitation was initiated.

Per the hospital discharge summary dated 10/01/21, Resident #4 was sent to ER on 09/24/21 for AMS due to a medication error at the facility. She was admitted to the hospital on 09/26/21 and discharged on 10/01/21. While in the ER, Resident #4's BS was back to normal, BP was stabilized, and her AMS was improved. Resident #4 was admitted to the hospital for further evaluation to ensure her mental status was back to the baseline.

An interview was conducted with the DON on 02/03/22 at 9:28 AM. While referring to the medication variance report, the DON stated she received a call the evening of 09/24/21 from Nurse #2 who stated that Nurse #1 had given Resident #4 medications prescribed for Resident #8. She asked Nurse #2 the status of Resident #4 and was told Resident #4 was alert but tired, and ready to go to sleep. She ordered Nurse #1

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to check the BS level for Resident #4 and the results were 144 mg/dl. Nurse #1 also checked Resident #4's VS which were BP 90/60, HR 68, T 97.6 F, and RR 16. She instructed Nurse #1 to call the on-call physician while Nurse #2 stayed with Resident #4. The on-call physician ordered to send Resident #4 to ER for evaluation. The last set of VS checked by Nurse #1 for Resident #4 before the EMS arrived were BP 80/58, HR 66, T 97.6 F, and RR 16. She stated Resident #4 had never been unresponsive while in the facility after the medication error incident on 09/24/21. The DON stated Resident #4 stayed alert and verbal even after the EMS arrived.

During a phone interview with Resident #4's RP on 02/02/22 at 12:43 PM, she stated Resident #4 was not a diabetic and she became unconscious after receiving medications, which included insulin, that were not prescribed for her.

During an interview with the NP on 02/03/22 at 10:16 AM, he stated the long acting Levemir could drop Resident #4's BS drastically, the carvedilol could drop her BP to an extent, and the trazodone and melatonin could make Resident #4 sedated.

A phone interview was conducted with the MD on 02/03/22 at 1:49 PM. He denied there were any long-term clinical impacts of insulin to Resident #4 as it would be eliminated out of her system in a few hours due to her weight. He stated Resident #4's BP of 70/40 was critically low, but denied it was directly related to those wrong medications. The MD indicated carvedilol, melatonin, and tizanidine could lower Resident #4's BP but not to a critical level in his opinion. The rest of the medications which included

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trazodone, melatonin, and tizanidine would only make Resident #4 sedated without causing any long-term clinical impacts. The MD added Resident #4 had a diagnosis of hypothyroidism and the clinical picture presented by Resident #4 in EMS or ER could mimic her hypothyroidism. He would expect Resident #4 to be drowsy from the wrong medications but not unresponsive.

The Administrator was notified of Immediate Jeopardy on 2/4/22 at 11:57 AM.

The facility provided the following corrective action plan with a completion date of 10/02/21.

On 9/24/21 at 9:30 PM, Nurse #1 entered room 212A and found Resident #4 in the bed. Nurse #1 called Resident #8's name and Resident #4 answered to Resident #8's name and engaged in conversation with Nurse #1. Due to Resident #4 responding to the name of Resident #8, Nurse #1 administered the medications.

At 10:10 PM, Nurse # 2 identified the error.

At 10:20 PM, Nurse #2 called DON to notify her of the medication error and DON directed Nurse #1 to take vital signs and blood sugar and give snacks with juice. DON instructed Nurse #1 to call the on-call MD while Nurse #2 stayed with Resident #4. Order received from on call to send Resident #4 to Emergency Room.

At 10:45 PM, vital signs taken by Nurse #1 and EMS arrived. DON told Nurse #2 to cover medication cart for Nurse #1. Nurse #1 was immediately in-serviced via telephone on 09/24/21 by the DON regarding the 6 Rights of Medication Administration. Nurse #1 was

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removed from the cart immediately following the medication error. Nurse #2 was educated as well.

Nurse #1 and # 2 were immediately in-serviced via telephone on 9/24/21 by the DON regarding the 6 Rights of Medication Administration; right person, right drug, right route, right time, right dose and right documentation. Nurse #1 was removed from the cart immediately following the medication error.

On 09/24/21 Resident #8 received her medication as ordered at 11:00 PM.

Staff education was initiated on medication administration immediately on 09/24/21 including the 6 rights of Medication Administration. This in-service was done via phone by DON on 09/24/21 with all nursing staff on shift at the time.

On 09/24/21 Responsible Party was notified at 10:35 PM. Medical Director was notified 09/25/21 via phone.

For the residents with the potential to be affected, staff education was initiated on 09/24/21 on medication administration, including the 6 rights of Medication Administration.

On 09/27/21, the DON completed in-person in-services on medication administration, all other nurses received her education via telephonic voice message system. No nurses were allowed to work after 09/27/21 until they completed the in-service. All new hires, those on vacation, and those who were as-needed staff were included in the telephonic voice message system in-service.

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On 09/27/21 100% audit of resident name tags on doors and photos in electronic record system was completed for accuracy.

On 09/27/21 alert and oriented residents were interviewed by Regional Operations Manager to ensure they received correct medications.

Starting the week of 09/27/21, the DON and Regional Nurse Manager completed a skills checkoff on medication administration for all new hires prior to any nurse conducting a medication pass, this would be ongoing.

On 9/30/21, the consultant pharmacist and nurse consultant visited Mecklenburg Health and Rehabilitation to perform a medication pass audit on 2 nurses. Both nurses observed were immediately corrected and re-educated regarding any errors made during the medication administration assessment.

Ad-Hoc Quality Assurance Meeting was held on 10/01/21 to discuss corrective action for the alleged deficient practice. Ad-Hoc meeting was attended by Medical Director via phone, Administrator, Director of Nursing, Regional Operations Manager, Regional Nurse, and Divisional Vice President in-person.

Starting 10/01/2021 three nurses would be assessed by the DON or Designee 3 nurses per week for 4 weeks, 1 nurse per week for 4 weeks; 3 nurses randomly for 1 month. Those completed medication pass without error, he or she will be assessed on a random basis going forward. Those with any errors noted during the medication pass assessment would be immediately re-educated by the DON or designee

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and would continue to be assessed weekly for 4 weeks or until they could pass a medication pass assessment.

Medical Records Director would update resident photos as needed. This process would be added to quarterly Quality Assurance. The Interdisciplinary Team would inform Medical Records Director of resident changes that might need photo update to ensure they reflected accurate resident likeness to ensure Resident Identity could be verified.

10 resident name plates would be checked at least weekly for 4 weeks by the Administrator or designee. Daily room rounds would include checking for correct name plate on door.

Consultant pharmacist would complete random medication pass audits monthly during routine visits.

This corrective action would be monitored by our quality assurance committee; however, any immediate or unanticipated adjustments that were deemed necessary to protect residents would be discussed in the morning meeting where the Administrator, DON and other facility leadership would be in attendance. This plan would also be revised as needed as a result of ongoing quality assurance discussions.

The facility's alleged correction date of 10/02/21 was verified by the following:

On 02/04/22, the facility's corrective action plan with correction date of 10/02/21 was validated on-site by record review, observation, and interview with resident and staff.

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F 760	Continued From page 15 Medication pass was conducted from 02/02/22 through 02/03/22. No concerns related to medication errors were identified. It consisted of 29 medications, 5 different residents, and 3 different nurses. Nurses were seen applying the 6 Rights of medication administration during medication passes. They were observed checking resident's picture in the computer, verifying the name plate at the door, and asking alert-oriented resident open-ended question for resident's name before administering medication. For residents who were nonverbal, nurses referred to another nursing staff to confirm residents identify before administering medication. Interviews with nursing staff from both shifts revealed they had been re-educated per the documentation of in-services provided related to effective identification of the right resident during medication administration. Nurses were knowledgeable about the 6 Rights of medication administration and observed utilizing the pictures, name plate, and open-ended questions or referring to another nursing staff to confirm the identification a resident before administering medication. Interviews with alert and oriented residents revealed nursing staff had been asking open-ended questions for their name before administering medication. The medication records of sample residents were reviewed with focus on medication error. No concerns related to medication errors were identified.	F 760		

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F 760	Continued From page 16 Review of in-service records revealed on 09/27/21, the DON completed the in-person in-services on medication administration. All other nurses not in the facility on 09/27/21 received the in-services via telephonic voice message system. The in-service sign-in sheet indicated all 15 nurses had received the re-education on 09/27/21. In addition, 14 new hires or "as needed" nurses had received the in-service from 10/04/21 through 02/03/22. Review of monitoring tools revealed the management staff had completed audits and monitoring per the audit tools and monitoring documentation provided.	F 760		