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	345526	A. BUILDING _____ B. WING _____	C 01/22/2024

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CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 01/22/24. The following intakes were investigated NC00212088, NC00211847, NC00211795 and NC00208129. 2 of the 7 complaint allegations resulted in a deficiency. Event ID # 0OKG11.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to have physician orders for tracheostomy (an opening surgically created through the neck into the trachea) care and provide nursing supervision of tracheostomy care as specified in the resident's plan of care for 1 of 1 resident reviewed for tracheostomy care (Resident #3). Findings included: Resident #3 was admitted to the facility on 7/7/2023 with diagnoses including throat cancer with tracheostomy. Resident #3 care plan dated 12/29/23 revealed the resident prefers to provide trach care with	F 695	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F695 1. Resident #3 admitted to the center on 1/22/2024. Resident #3 has tracheostomy with no orders for tracheostomy care to be performed. 2. Current residents with tracheostomy are at risk. No further patients with	2/9/24

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

Electronically Signed | 02/06/2024

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F 695	Continued From page 1 supervision of nurse. The goal was that the resident will have their preferences honored if possible. Interventions is to review resident's preferences with them as needed. Review of Resident #3 care plan dated 10/10/23 and revealed at risk for complications secondary to a tracheostomy secondary to history of cancer care plan. The goal was for the resident not to have complications related to having a trach. Interventions were: change trach tie as ordered, humified oxygen as order, monitor skin integrity under trach collar, nebulizer treatments as ordered, observe for signs and symptoms of respiratory complication including infection and respiratory blockage, oxygen per orders, SLP referral as indication, suction as needed, tracheostomy care per orders, and trach tie changes. A review of physician orders revealed the following: - A physician order dated 12/21/23 for "okay to lavage tracheostomy as needed". This order was discontinued on 1/08/24. - A physician order dated 11/1/23 to change inner cannula every night shift and as needed and tracheostomy care every shift. This order was discontinued on 1/08/24. - On 1/16/2024 a new order for humified oxygen at 4 Liters via tracheostomy mask. Review of medical records revealed that Resident #3 was sent to the emergency department for evaluation on 1/08/23 and returned to the facility the same day. An interview and observation were conducted with Resident #3 on 1/22/24 at 12:05 PM. She	F 695	tracheostomy present in center at present time. 3. Chart review of current residents with tracheostomies performed by Director of Nursing on 1/22/2024. Orders for tracheostomy care was entered into Resident 3 # chart. Current licensed nurses will be educated by the Staff Development Coordinator or designee on transcription of tracheostomy care and timeliness of entering tracheostomy care orders upon admission. This education will be completed by 2/09/2024. Licensed nursing staff not receiving education will not be allowed to work until education received. New licensed nursing staff will receive education within the orientation process by the staff development coordinator. 4. Director of Nursing or designee will audit new admission charts within 24 hours to ensure that tracheostomy care orders are entered. Audits will occur 5 times weekly x 4 weeks then 3 times weekly x 4 weeks, then once weekly x 4 weeks. 5. The Director of Nursing will provide Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed. Date of completion 2/09/2024	

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F 695	Continued From page 2	F 695		

stated that she did her own tracheostomy care, and that staff did not assist her. The Resident reported staff assessed and suctioned her tracheostomy when she asked them to or was having trouble and needed to be suctioned. Resident #3 explained that Duke hospital taught her how to care for her tracheostomy before she was discharged. The Resident further stated that nursing staff did not watch her do tracheostomy care and a third shift nurse gave her supplies when she needed to change her tracheostomy. Resident #3 tracheostomy was clean and clear. No mucous was noted, tracheostomy straps were clean, and resident showed no signs of difficulty breathing.

An interview with Nurse #2 on 1/22/24 at 12:55 PM. She stated she has taken care of resident #3 but has never provided tracheostomy care and has only suctioned Resident #3 a few times when the resident has asked for it to be done. Nurse #2 stateed she was not very comfortable taking care of the tracheostomy, but that the Resident #3 knew how to take care of it.

An interview with Nurse #3 on 1/22/24 at 1:03 PM revealed Resident #3 was independent with caring for her tracheostomy, and they only suctioned as needed. She noticed they are having to suction more often, but she stated this was due to the resident's condition. Nurse #3 confirmed she had received tracheostomy care training from the facility and would be able to care for the resident if she had to when it came to tracheostomy.

Interview with Respiratory Therapist (RT) on 1/22/24 at 2:06 PM revealed she worked with Resident #3 and provided education concerning

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F 695	Continued From page 3 her tracheostomy and the progression of her cancer. The RT stated she has changed and cleaned Resident #3's tracheostomy during visits, and with the new humified oxygen and resident letting staff suction her she had noticed some improvement with mucous plugs. An interview with the Medical Director (MD) at 1:11 PM revealed that Resident #3 was receiving humidified oxygen through her nasal cannula, but as her disease has progressed, she has been put on humified tracheostomy oxygen at 4 Liters on 1/16/24 and this seemed to be helping the resident with preventing the tracheostomy from clogging. The Medical Director was not aware that there were no orders for tracheostomy care on the resident's chart. The MD stated that the resident anxiety is very high when it comes to her tracheostomy and airway and would demand to go to the hospital to have it checked out. The MD further stated Resident #3 was not accepting of her prognosis and is seeking a second opinion, but there was nothing else that can be done for her metastatic cancer. Interview with the Director of Nursing (DON) on 1/22/24 at 1:30 PM revealed the DON was not aware there were no active orders for Resident #3's tracheostomy care. The DON stated she thought the resident was care planned as preferring to do her own tracheostomy care and was not aware the care plan stated with nursing supervision.	F 695		
F 760 SS=G	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	F 760		2/9/24

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F 760	Continued From page 4 medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and family member, staff, and Medical Director interviews, the facility failed to prevent significant medication errors when Medication Aide #1 administered medications prescribed for Resident #2 to Resident #1 which include Clonazepam (a medication to treat anxiety), Buspar (a medication to treat anxiety), Gabapentin (anticonvulsant medication), Seroquel (antipsychotic medication) and Trazodone (antidepressant) for which he had no diagnosis and all had the potential side effects of dizziness and drowsiness. Resident #1 was sent to the emergency department on 12/08/23 for further evaluation where it was determined he had an accidental drug overdose as evidenced by Resident #1 having altered mental status and drowsiness. Resident #1 was admitted into the hospital for observation after continued altered mentation and no return to normal baseline and was discharged on 12/12/23. This deficient practice affected 1 of 3 residents reviewed for significant medication errors (Resident #1). Findings included: Resident #1 was admitted to the facility on 12/02/23 with a diagnosis that included atrial fibrillation, cardiomyopathy, lung disease and pneumonia. The resident's admission Minimum Data Set (MDS) assessment dated 12/03/23 revealed Resident #1 was cognitively intact. The resident was not coded as receiving antidepressant, antipsychotic, or antianxiety medications.	F 760	F760 1. Resident #1 received Resident # 2 medications by Certified Medication Aide. This occurred on 12/08/2023. The resident was transferred to the hospital. 2. Current residents are at risk . 3. At the time of discovery, the Certified Medication Aide immediately self-reported the error to the licensed nurse overseeing her. Resident was immediately assessed by licensed nurse with no change of condition noted, ON-Call provider was notified by licensed nurse and ordered for patient to be evaluated at the hospital to ensure no adverse reactions from sedating medication given. The supervising licensed nurse notified the Director of Nursing and Resident #1 family at the time of error; education was provided to the certified medication aide regarding the five rights of medication administration at the time of error by licensed nurse. On 12/11/2023 the Director of Nursing continued the investigation and discussed medication error with facility Nurse practitioner. Education initiated on 12/11/2023 to include the five rights of medication administration by the staff development coordinator. Education provided to current certified medication aides and to current licensed nurses. No licensed nursing staff or certified medication aides will be allowed to work	

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F 760	Continued From page 5 Review of the December 2023 physician orders for Resident #1 revealed the following medications: - Cefdinir (antibiotic) 300 milligrams (mg) 1 capsule by mouth every 12 hours for a urinary tract infection for 10 days - Eliquis (anticoagulant) 5 mg 1 capsule by mouth every 12 hours for deep vein thrombosis prevention - Sotalol (beta blocker) 80mg 1 capsule by mouth every 12 hours for atrial fibrillation. Resident #2 was admitted to the facility on 12/02/23. Review of the December 2023 physician orders for Resident #1 revealed the following medications: - Clonazepam 0.5 milligram (mg) 1 tablet by mouth every 12 hours for bipolar disorder. - Buspar 30 mg 1 tablet by mouth every 12 hours for anxiety. - Gabapentin 400 mg 1 tablet by mouth four times a day for neuropathic pain - Remeron 15 mg 1 tablet by mouth at bedtime for bipolar disorder - Seroquel 100mg 2.5 tablets by mouth at bedtime for bipolar disorder - Trazodone100 mg 1 tablet by mouth at bedtime for insomnia An incident report dated 12/08/23 written by Nurse #1 revealed Resident #1 had received Resident #2's medication which included: Clonazepam 0.5 mg, Buspar 30 mg, Gabapentin 400 mg, Remeron 15 mg, Seroquel 100mg and Trazodone 100 mg. The report revealed Resident #1 did not receive his scheduled medication. The incident was reported to the on-call physician at	F 760	until education received. New licensed nursing staff and new certified medication aides will receive education on the five rights of medication administration during the orientation process. 4. Current licensed nurses and current medication aides will have medication pass observation performed by Director of Nursing/Staff Development Coordinator or designee. This will be completed by 2/09/2024. Director of Nursing/Staff Development Coordinator or designee will complete medication pass observations 5x weekly x8 weeks, then 3 times weekly x 8 weeks, then weekly x 8 weeks. 5. The Director of Nursing will provide Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Date of completion 2/09/2024 The administrator is responsible for compliance	

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9:30 PM after the Medication Aide had immediately reported the medication error to Nurse #1. Nurse #1 assessed the resident; Resident #1 was noted to be in no acute distress. Resident #1 was noted to be alert and oriented when he left the facility. A follow up was conducted with Resident #1's family members regarding the medication error. The family members stated Resident #1 had some sedation in the hospital but otherwise was doing well following the incident.

An interview conducted on 1/11/24 at 9:31 AM with Medication Aide (MA) #1 revealed on 12/8/2023 she was completing her medication pass at 9:30 PM with two residents left to medicate (Resident #1 and Resident #2). MA #1 stated she was in a hurry to complete the medication pass because the computer system was turning red indicating the medications were late. She stated she removed both residents' medication from the medication cart at the same time and had both cups of medication in her hand when walking down the hall into Resident #1's room. MA #1 stated she handed Resident #1 a cup of medications and as he was swallowing, she realized she had given Resident #1 Resident #2's medications. She stated she immediately realized the mistake and notified Nurse #1 she had given Resident #1 the incorrect medication. The interview revealed Nurse #1 told her to obtain vital signs on Resident #1 while she notified the on-call physician. She stated Resident #1's vital signs were within normal range, and he was alert after the incident. She stated Emergency Medical Services EMS) arrived to transport Resident #1 to the hospital for an evaluation. The interview revealed Resident #1 was alert and not drowsy prior to leaving the facility.

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Resident #1's documented vital signs dated 12/08/23 at 9:30 PM revealed the following: blood pressure 116/71 (normal range systolic (top number) less than 120 and diastolic (bottom number) less than 80), temperature 96.6 (normal range 97 to 99), pulse 77 beats per minute (normal range 60-100), respirations 16 breaths per minute (normal range 12-20), oxygen saturation 95% (normal range 92% or greater) on room air.

An interview conducted on 1/11/24 at 9:41 AM with Nurse #1 revealed she was working on the night of 12/08/23 when Medication Aide #1 came to her and stated she had administered the wrong medication to Resident #1. The interview revealed she asked MA #1 to obtain vital signs on the resident while she called the on-call physician. She stated she did not recall the name of the on-call physician but that she was given orders to send Resident #1 to the hospital for an evaluation. Nurse #1 stated she then went into Resident #1's room to assess him and noted he had no change of condition and did not seem drowsy prior to EMS arrival.

Hospital records dated 12/08/23 revealed Resident #1 was evaluated in the Emergency Department (ED) due to being given the wrong patient's medication at the nursing facility. Resident #1 was noted to be awake but drowsy upon arrival at the hospital. Resident #1 was treated with intravenous fluids in the ED and the physician noted Resident #1 to be oriented and to answer questions appropriately. In the ED Resident #1 denied any shortness of breath, chest pain, nausea, vomiting, diarrhea, or abdominal pain. Resident #1 was noted to be

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non-toxic in appearance, sleepy but arousable. Resident #1 was given a diagnosis of encephalopathy due to an accidental overdose. The ED conducted lab work, electrocardiogram, and imaging studies all of which were noted to be negative for abnormal findings. The resident was admitted into the hospital for observation. A toxicology lab report dated 12/09/23 at 12:55 AM revealed negative for benzodiazepines, amphetamines, barbiturates, and opiates in Resident #1's blood work. Resident #1 was discharged from the hospital on 12/12/23.

An interview conducted on 1/11/24 at 8:48 AM with Family Member #1 revealed she was contacted on 12/08/23 at 10:00 PM by Nurse #1. She stated Nurse #1 told her that a Medication Aide had administered the wrong medication to Resident #1 and that he had been sent to the hospital for an evaluation. The interview revealed Resident #1 had some drowsiness from the incident but no other symptoms. She stated she did not want the resident to go back to the facility, so he finished inpatient rehabilitation at the hospital and was discharged home with home health.

An interview conducted on 1/11/23 at 11:17 AM with the facility Medical Director (MD) revealed on 12/8/23 Resident #1 received a number of medications prescribed for another resident. He stated Resident #1 had not received a toxic dose of any of the medications and had not experienced any extreme sedation or respiratory depression from the medication. The MD stated it was an unacceptable error made by the facility staff but Resident #1 did not have any significant adverse effects from receiving the medication other than drowsiness. The MD stated he had

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reviewed Resident #1's labs, his kidneys were in good condition and the medication he received would have been out of his system within 48 hours. He stated the hospital had given the resident a diagnosis of encephalopathy due to receiving several sedative medications that he normally did not take. He stated the diagnosis would have come from Resident #1 having an altered mental status upon his arrival to the hospital.

An interview conducted on 1/11/24 at 1:47 PM with the Director of Nursing (DON) revealed on 12/08/23 she was notified by Nurse #1 that a medication error had occurred. The DON stated Nurse #1 had immediately contacted the on-call physician and obtained orders to send Resident #1 to the hospital for an evaluation. The interview revealed the nurses and medication aides in the facility should not be pre-pulling two residents' medication at the same time. The DON stated the error had occurred because the Medication Aide had pre-pulled the medication and removed both residents' medication at the same time creating the possibility for error.

An interview conducted on 1/11/24 at 2:51 PM with the Administrator revealed the DON had notified her of the medication error. She stated Nurse #1 had immediately notified the physician, assessed the resident, and notified the resident's family member following the incident. The Administrator stated the staff did everything they should have after the incident occurred. She stated nursing staff should have provided the correct medication to the correct resident.