STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 The surveyor entered the facility on 06/12/24 to conduct a complaint survey and exited on 06/12/24. Additional information was obtained on 06/13/24. Therefore, the exit date was changed to 06/13/24. Event ID# 1T0L11. The following intake was investigated: NC00217934. One (1) of the 2 complaint allegations resulted in a deficiency.	F 000		
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 medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, Medical Director, Nurse Practitioner, staff and resident interviews the facility failed to prevent a significant medication error for 1 of 3 residents reviewed for medication administration when two blood pressure (BP) medications, Isosorbide mononitrate and hydralazine were not administered per orders for Resident #1. This resulted in Resident #1 ' s BP to drop to 82/50 causing a near syncope event that required a visit to the emergency room for further evaluation. The findings included: Resident #1 was admitted to the facility on 5/22/24 with diagnoses that included, hypertension (HTN) (high blood pressure), acute cerebral vascular accident (CVA) (an interruption in the flow of blood to cells in the brain), coronary artery disease (CAD) with history of two myocardial infarctions (MI) (heart attack), and	F 760	Resident #1 has a diagnosis of hypertension. The facility failed to follow parameters for blood pressure medication orders for Resident #1. Resident # 1 had a BP of 112/61 on 6/4/2024 around 9:00 AM. Nurse # 1 failed to hold 2 medications for Resident # 1. Nurse # 1 administered hydralazine with parameters to hold if SBP is less than 120; and isosorbide mononitrate with parameters to give if B/P is greater than 160/90. On 6/4/24 the Director of Nursing educated Nurse #1 on reading the physician order and following all medication parameters□ before administering the medication. At approximately 10:40 AM, Nurse # 1 heard Resident # 1□s son yelling for help, stating his mother was unresponsive and sweating. Vitals were taken and BP was 82/60. EMS was called and Resident # 1□s BP was 104/66. Resident was sent	6/27/24

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

Electronically Signed | 07/01/2024

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F 760	Continued From page 1 coronary artery occlusion. The most recent Minimum Data Set (MDS) coded as an admission assessment on 06/02/24 revealed Resident #1 was cognitively intact. No behaviors coded and no rejection of care were coded. Record review of active medications revealed an order dated 05/27/24 that read in part, hydralazine 50 milligram (mg) tablet: give 1 tablet; by mouth, three times a day. (Hold for systolic blood pressure (SBP) less than 120 related to essential (primary) hypertension. It also revealed an order dated 05/27/24 that read in part, isosorbide mononitrate 30 mg tablet extended release over 24 hours; give 1 tablet; by mouth once a day for BP greater than 160/90. The Medication Administration Record (MAR) for June 2024 revealed Resident #1 ' s BP reading to be 112/61 on 06/04/24 at approximately 9:00 AM. The MAR also revealed hydralazine 50 milligram (mg) tablet, hold for systolic blood pressure (SBP) less than 120 and isosorbide mononitrate 30 mg tablet extended release tablet, give once a day for BP greater than 160/90 was administered by Nurse #1. A phone interview was conducted with Resident #1 ' s responsible party on 06/12/24 at 9:52 AM. He stated when he arrived at the facility Resident #1 was in her wheelchair sitting outside in the courtyard. She was in the sun, not responding to him and she had sweat on forehead. He then stated he thought she had another stroke because when she opened her eyes and started talking to him her speech sounded slurred. He indicated this had happened before and that her	F 760	to the ER via Emergency Medical Services per son□s request. Per the resident□s RP her blood pressure fluctuates and sometimes bottoms out. Resident # 1 returned to facility on 6/4/2024 around 9:00 PM with no concerns noted from discharging hospital CCH. An ad hoc QAPI meeting was held on 6/4/24 to discuss the deficient practice and to initiate a plan of correction and education for staff regarding following physician orders for medication administration. All residents with orders for medications with parameters are at risk for this deficient practice. Record review was conducted by the Regional Clinical Director of residents with medication orders with parameters. Records for the last 30 days were reviewed for any treatment of low blood pressure levels that were unreported, documented incorrectly and not monitored. On 6/27/24 the Director of Nursing completed a medication administration observation utilizing form CMS-20056 Medication Administration Observation to monitor that residents are being administered medication as ordered. Monitoring included observations of three (3) licensed nurses and one (1) medication aide for five (5) random residents each, to include a total of forty (40) medication administration observations.Forty(40) medications were administered without error during the observation.	

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F 760	Continued From page 2 BP goes up and down a lot. He further stated he yelled into the building for help and the nurse came to assist. An interview was conducted with Nurse #1 on 06/12/24 at 1:23 PM. She verified she was Resident #1 ' s nurse on 06/04/24. She stated she checked Resident #1 ' s BP then administered hydralazine 50 mg 1 tablet and isosorbide mononitrate 30 mg tablet on 06/04/24. She indicated she did not thoroughly read the orders which included parameters for both medications. She further stated the hydralazine 50 mg tablet was to be held if her systolic blood pressure was below 120 and the isosorbide mononitrate 30 mg tablet was to be given for a BP greater than 160/90. She then indicated she was unaware of the parameters for the medications due to not thoroughly reading the orders. An interview was conducted with the Director of Nursing (DON) on 06/12/24 at 11:20 AM. The DON stated she was alerted by the voice of Resident #1 ' s responsible party that his mother appeared to be having another stroke. She then went to assist Nurse #1 with assessing Resident #1. She also stated Nurse #1 took her vital signs which were BP 82/50, temperature 97.1 axillary, and oxygen saturation was 98% on room air. She also had sweat on her forehead. Emergency Medical Services (EMS) were called for a possible stroke and while awaiting their arrival Resident #1 ' s BP went up to 104/66, she was alert and verbally responsive. Resident #1 ' s responsible party stated her BP fluctuates and sometimes bottoms out. She returned from the hospital with no issues noted. A review of Resident #1 ' s medication administration record	F 760	On 6/4/24 the Regional Clinical Director educated the Director of Nursing and the Staff Development Nurse (SDC) regarding the medical director's parameters for all residents on medications with parameters. The nurse will transcribe the parameter orders to the medication administration record. Including in the education was notification of the physician for administration of medication that were outside the parameters. The Director of Nursing and Staff Development Nurse began education on 6/4/24, for Licensed nurses and Medication Aides on the following, with a posttest required to ensure understanding: " Education was provided to the nurses regarding the medical director's parameters for all residents on medications with parameters. The nurse will transcribe the parameter orders to the medication administration record. Including in the education was notification of the physician for administration of medication that were outside the parameters. Anyone not receiving education will not be allowed to work until education has been completed. Education will be added to the new hire orientation for Licensed Nurses conducted by the DON or Staff Development Nurse. The Administrator informed DON and the Staff Development Nurse they will keep a list of all staff trained to ensure no staff work until training is completed. On 6/4/24 the DON and the SDC Nurse began education with all licensed nurses and medication aides on 6 rights of	

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F 760	Continued From page 3 (MAR) for 06/04/24 revealed a medication error related to BP medications being given outside of parameters to hold. She indicated that the medications should be given per order. Emergency Medical Services (EMS) records dated 06/04/24 revealed Resident #1 was assessed at the facility upon arrival at 10:52 AM. Call came in as possible stroke. Resident #1 ' s vital signs were as follows: blood pressure 128/69, pulse 77, respirations 14, temperature 98 degrees. Stroke screen with negative findings. Heart monitor applied and noted atrial fibrillation (A-Fib) present. Attempts to start intravenous saline lock times 2 were unsuccessful. Resident #1 was alert and oriented to event, person, place, and time. Skin diaphoretic, flushed, and hot. Emergency Room records revealed Resident #1 arrived on 06/04/24 at 11:30 AM with a damp gown on, awake, alert and oriented. She denied any pain and her responsible party stated she was close to her baseline. Her discharge diagnosis was near syncope (fainting or passing out), and no medications were given. Electrocardiogram (EKG) was performed which indicated A-Fib and a series of blood tests. No treatments, no intravenous fluids, or vital signs listed on emergency department records dated 06/04/24. An interview was conducted with the Administrator on 06/12/24 at 11:25 AM. She indicated that the medications should be given per order. She stated that an ad hock (as needed) Quality Assurance Performance Improvement (QAPI) meeting was held on 06/04/24 to discuss the deficient practice, initiate the plan of correction and education for staff	F 760	medication administration, potential adverse effects of missed medications, documentation requirements regarding omissions, significant medication errors, and administering medications. Anyone not receiving education will not be allowed to work until education has been completed. Education will be added to the new hire orientation for Licensed Nurses and Medication Aides conducted by the DON or Staff Development Nurse. The Administrator informed DON and the Staff Development Nurse they will keep a list of all staff trained to ensure no staff work until training is completed. To prevent this from recurring, the SDC Nurse or designee will observe two med passes weekly for four weeks, and one med pass weekly for four weeks to ensure no medication errors are made. The findings of these audits will be reported to the QAPI committee by the Administrator for further review or need to continue audits. Date of Compliance: 6/27/2024	

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F 760	Continued From page 4 regarding following physician orders for medication administration. Review of the plans to monitor performance revealed the Staff Development Nurse or designee would review medication administration records to ensure physician parameters are followed for hypertension orders. This plan would not prevent another medication error from occurring.	F 760		