STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	25 SUNNYBROOK ROAD RALEIGH, NC 27610

(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 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to ensure a medication error rate of less than 5% for 25 opportunities observed (medication administration error rate of 8.0%, 2 errors out of 25 opportunities for Residents #150). Findings included: Resident #150 was admitted to the facility on 08/13/2014 with diagnoses that included anemia and asthma with cough for which she was prescribed ferrous sulfate 325 milligrams (mg) by mouth once daily at 6:00 PM, calcium 600 mg plus vitamin D3 by mouth daily, and Mucinex 600 mg by mouth twice daily. 1 A) Nurse #1 was observed during medication administration on 09/11/2014 starting at 8:00 AM. At 8:12 AM, the nurse was observed administering the ferrous sulfate 325 mg by mouth once daily. She retrieved Calcium 600 mg plus vitamin D3 from the medication storage room and administered it to the resident at 8:45 AM. The United States National Library of Medicine/National Institute of Health website indicates that calcium makes it harder for the body to absorb iron either from food or supplements. Their recommendation to minimize this interaction is to separate the intake of calcium and iron by two or more hours.	F 332	*Nurse #1 was provided one to one education on medication administration, compliance with medication times, and following physician orders for medication administration. Nurse #1 was observed by SDC/Pharmacist on medication pass two times with no medication errors observed. *Nurses and Medication Aides were provided education on medication administration, compliance with medication times, and following physician orders for medication administration. *DON/ADON/SDC or Nurse Supervisor will randomly observe five Nurses or Medication Aides per week for three months to validate Nurses and Medication Aides are compliant with medication administration, medication times, and following physician orders for medication administration. Any Nurse or Medication Aide who is observed to have an error will be removed from the medication pass, provided additional education by the SDC, Pharmacy Consultant, DON or Nurse Supervisor,and will not be permitted to perform medication administration pass alone until deemed proficient by the DON/ADON/SDC, or Nurse Supervisor.	10/3/14

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

Electronically Signed | 10/01/2014

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F 332	Continued From page 1 1 B) Nurse #1 was observed to administer Mucinex DM (with dextromethorphan) 600 mg 1 tablet by mouth on 9/11/14 at 8:12 AM. After reconciling the orders, Nurse #1 was interviewed on 09/11/14 at 2:00 PM. She stated that she became aware that she had administered the ferrous sulfate at the incorrect time and had reported the issue to her supervisor who was in the process of compiling an incident report. She further stated that she was not aware that Mucinex DM and Mucinex were products that contained different ingredients. The Director of Nursing was interviewed at 2:30 PM on 09/11/14. She stated that Nurse #1 had been recently assigned to the task of medication administration. She stated that her expectations were that all nursing staff provided residents their prescribed medications free from unnecessary or significant medication errors.	F 332	DON/ADON will tabulate data and present to the center's monthly Quality Assurance and Performance Improvement Committee. *Monthly for three months, the Quality Assurance and Performance Improvement Committee will review the results of the medication administration pass. The Quality Assurance and Performance Improvement Committee will make recommendations as needed to ensure compliance is sustained ongoing.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		10/8/14

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F 431	Continued From page 2 instructions, and the expiration date when applicable. 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. 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 observations and staff interview, the facility failed to discard 3 bottles of expired stock medications from 1 of 5 medication carts. Findings included: Observations on 09/09/14 at 9:30 AM of medications stored in the facility ' s hallway medication cart revealed 3 bottles of expired stock medications. These included a bottle of Ferrous Gluconate 240 milligrams which expired on 06/14 and 2 bottles of Vitamin E 200 International Units which expired on 08/14. Nurse #2, who was using the medication cart, was interviewed on 9/9/14 at 09:35 AM. She stated that she did not know that the expired	F 431	*Nurse #2 was provided one to one education to check expiration dates prior to medication administration and to properly discard any expired medication noted in the medication cart. Nurse #2 did not administer expired medication. *Nurses and Medication Aides were educated to check expiration dates prior to medication administration and to properly discard any expired medication noted in the medication cart. Consulting Pharmacist was educated to check for and properly discard any expired medications monthly during medication routine/ random medication pass	

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F 431	Continued From page 3 medications were in the medication cart and relied on the facility ' s consultant pharmacist to inspect for expired medications. Nurse #2 also stated she checked for expiration dates prior to administering medications, and had not administered any medications from these expired stock bottles. The Assistant Director of Nursing was interviewed on 9/9/14 at 10:58 AM. She verbalized her expectation that medication carts should be free of expired medications, which are to be checked by both nursing staff and the consulting pharmacist.	F 431	observations. *Nurse/Medication aides check expiration dates prior to medication administration. Nurse/Medication aides will complete a full cart audit two times weekly to validate there are no expired medications on the carts. *DON, ADON, and SDC or Nurse Supervisor will randomly observe the center's medication carts once weekly for three months to validate there is no expired medication located in the medication carts. Any Nurse or Medication Aide noted to have expired medication on their medication cart will be removed from their assignment, and provided one to one education by the SDC,Pharmacy Consultant, DON or Nurse Supervisor prior to performing additional medication administration pass. DON/ADON will tabulate data and present to the center's monthly Quality Assurance and Performance Improvement Committee. *Monthly for three months, the Quality Assurance and Performance Committee will review the results of the medication cart audits. The Quality Assurance and Improvement Committee will make recommendations as needed to ensure compliance is sustained ongoing.	