STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345152	A. BUILDING ______ B. WING ______	C 01/31/2017

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TRINITY VILLAGE	1265 21 STREET NE HICKORY, NC 28601

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F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility administered a medication which was not ordered/indicated for 1 (Resident #1) of 3 residents sampled for unnecessary medication. The Findings included: Resident #1 was admitted to the facility on 08/16/16 with diagnoses that included: Alzheimer's disease, dementia, and others. Review of the most recent quarterly minimum data set (MDS) dated 11/09/16 revealed that Resident #1 was cognitively intact and required extensive assistance with activities of daily living. Review of cumulative physician orders dated	F 329	1) Immediately upon being notified of the med error by the affected resident's family on 1-21-17, the nurse instructed the med aide to remove the Exelon patch. The nurse reported the med error to the nursing supervisor. The facility medical director was also notified of the error on 1-21-17. The nurse obtained vital signs and continued to monitor the resident for adverse reactions on 1-21-17. There were no adverse reactions. Both male residents have the same first name and shared a room, which may have been a contributing factor to the	2/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/15/2017

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 329	Continued From page 1 01/01/17 through 01/31/17 revealed no order for Exelon Patch (a patch used to slow the progression of Alzheimer's disease and dementia). Review of the facility's medication error report dated 01/21/17 revealed that Nurse #2 applied a Exelon patch to Resident #1 that was ordered and intended for another resident. The medication error report also indicated that there were no adverse reactions noted to Resident #1. Interview with Resident #1 on 01/30/17 at 4:24 PM revealed that on 01/21/17 Nurse #2 applied an Exelon patch to him that he later learned was not intended for him. Resident #1 stated that he had the Exelon patch on for less than an hour and he had no side effects from it, it did not make Resident #1 feel "funny" or "different". Resident #1 explained that his family had come to visit him that day and they noticed the patch that was visible on his shoulder area. The family member had questioned staff about it, and that was when it was discovered that it was intended for my roommate. Resident #1 stated that Nurse #2 had checked his vital signs and instructed him to let her know if he started feeling differently. Interview with Nurse #2 on 01/31/17 at 11:39 AM revealed that on 01/21/17 at approximately 8:30 Am she had already medicated Resident #1 and had returned to the medication cart to sign the medication administration record. Nurse #2 stated she had started preparing Resident #1's roommate medications including the Exelon patch when she got called away from the medication cart by staff on the hall. Nurse #2 recalled that when she returned to the medication cart she saw the Exelon patch in the top drawer and realized she had not applied it so she returned to Resident #1's room and just "accidentally" applied it to Resident #1 instead of	F 329	error. The residents are no longer roommates as of 1-25-17. The resident affected now resides on a different hall. 2) It is determined that all residents have the potential to be affected. The DON will review facility policy and in-service the nursing staff on 2-20-17 to discuss the importance of identifying and confirming the right resident during medication administration. At this same meeting on 2-20-17, the DON will in-service the staff on how to handle interruptions during a med pass. Staff unable to attend the meeting on 2-20-17 will be required to see the SDC no later than 2-28-17 for a one-on-one in-service and review. 3) At the next nursing department meeting on 2-20-17, the DON will re-educated nurses and med aides on the "5 Rights of Medications Administration". The DON will use the current example to show the importance of being intentional and focused while following proper protocol when administering medications. Staff unable to attend the meeting will be required to meet with the ADON no later than 2-28-17 to receive a one-on-one in-service training and review. The DON will initiate a friendly reminder by laminating a card with the "5 Rights of Medication Administration", which will be located on or near the med cart. These reminders will be available by 2-28-17.	

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F 329	Continued From page 2 the roommate. Nurse #2 stated that Resident #1's family asked Medication Aide (MA) #1 about the patch present on Resident #1. MA#1 called Nurse #2 to inquire about the patch on Resident #1's shoulder and that was when Nurse #2 discovered she had applied the Exelon patch to the wrong patient. Nurse #2 instructed MA#1 to remove the patch from Resident #1. Nurse #2 stated she reported the error to her nurse supervisor, obtained vital signs and observed him for any adverse reactions for the rest of her shift. Nurse #2 stated that Resident #1 had no adverse reactions. Nurse #2 stated after the error occurred she mentioned to the facility management that both Resident #1 and the roommate had the same first name and that was something she felt like contributed to the error. Nurse #2 stated she had not received any additional training on medication administration since the error occurred but she did discuss the error with her Director of Nursing (DON). Interview with Nurse Supervisor #1 on 01/31/17 at 11:51 AM revealed that on 01/21/17 Nurse #2 had reported to him that she had accidentally applied an Exelon patch to Resident #1 instead of his roommate. Nurse Supervisor #1 stated that he advised Nurse #2 to check Resident #1's vital signs and to keep a close eye on him for any adverse reactions. Nurse Supervisor #1 stated that he had then reported the error to Nurse Supervisor #2 who was going to be contacting the physician about a list of things including the error. Interview with Nurse Supervisor #2 on 01/31/17 at 12:19 PM revealed that he had received in report from Nurse Supervisor #1 that Nurse #2 had made a medication error by accidentally applying an Exelon patch to Resident #1 instead of his roommate. Nurse Supervisor #2 stated the he	F 329	The DON and ADON will review the med error report monthly. They will provide in-service training for staff with any identified trends. The DON and ADON will share the med error reports at nurses meetings to serve as a reminder for staff. The SDC will add a Relias training course for nurses and med aides on the topic of Medication Administration. The training will be required annually. 4) The SDC will complete weekly audits to include monitoring 2 med passes for the next 4 weeks to ensure medications are being dispersed correctly. All med errors will be investigated and the appropriate actions taken, including a systems review, coaching, or disciplinary action for the staff member involved. Results from the audit will be shared and reviewed during QAPI meetings for trending and tracking purposes with follow up action taken as needed. Monitoring will be ongoing. All corrective action will be completed by 2-28-17.	

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F 329	Continued From page 3 assessed Resident #1 for weakness, behavior changes, and nausea and vomiting and Resident #1 had none of those. Nurse Supervisor #2 stated he notified the physician of the error and he stated "that was ok". Nurse Supervisor #2 stated that Resident #1 had no adverse reactions from the error and was his usual self the remainder of the day Interview with MA #1 on 01/31/17 at 1:00 PM revealed that on 01/21/17 she was working on the unit and Resident #1 and his family approached her and asked if she knew anything about the patch that was on Resident #1's shoulder. MA #1 stated it had been several days since she worked with Resident #1 so she called Nurse #2 and asked about the patch. MA #1 stated that Nurse #2 realized that she had applied the patch to the wrong patient and asked MA #1 to please remove the patch. MA #1 stated she removed the patch as instructed by Nurse #2. MA #1 stated that later in the day she had asked the Nurse Supervisor if he had been made aware of the error and the nurse supervisor replied "yes". MA #1 stated she had not received any education on medication administration since the incident. Interview with the DON on 01/31/17 at 1:11 PM revealed that when a nurse made a medication error they were required to fill out a medication error report and notify the physician of the error for any new orders. "Generally we are instructed to just monitor the resident for any adverse reactions and of course if there are any we would again notify the physician. Resident #1 had no adverse reactions from the Exelon patch that was accidentally applied to him instead of the roommate. After the event we looked at what actually happened and I talked to Nurse #2 and found that she had been called away from her medication cart." The DON stated that when she	F 329		

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F 329	Continued From page 4 talked to Nurse #2 it was an informative session to find out what happened and at the time. "I did not think she needed any reeducation because she was able to verbalize to me what she should have done." Nurses received the medication training with their orientation process and then annually through the online course offered by the facility. The DON stated she had a nurse meeting on 12/21/16 but medication administration was not on the topic of things discussed. The DON stated she expected the nursing staff to use the 5 rights of medication administration (the right medication, with the correct dose, to the right patient, at the right time, via the correct route).	F 329		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		2/28/17

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F 431	Continued From page 5 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (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. (h) Storage of Drugs and Biologicals. (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. (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 secure a medication cart when left unattended for 1 of 1 observed medication carts. The findings included: On 01/30/17 at 4:13 PM an observation of the 600 hall medication cart was made. The cart was positioned halfway down the hallway, was unlocked and unattended. There was one	F 431	1) No residents were affected, but the staff member involved was counseled on 1-30-17 by the DON. 2) Residents on the 600 Hall had the potential of being affected. Upon realizing the cart was left unlocked on 1-30-17, the nurse locked the cart and immediately	

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F 431 Continued From page 6

resident sitting in a wheel chair approximately 2 feet in front of the unlocked and unattended medication cart. There were 2 other residents ambulating in the hallway directly in front of the unlocked and unattended medication cart. After 6 minutes Nurse #1 returned to the cart and verified that the medication cart was unlocked.
Interview with Nurse #1 on 01/30/17 at 4:18 PM revealed that she had been called away from the medication cart by the staff on the hallway, Nurse #1 stated she thought she had pushed the lock button in but "I guess it did not lock". Nurse #1 stated she always locked her cart when she walked away from it and she was aware that the medication carts should be locked at all times when not in her view.
Interview with the Director of Nursing (DON) on 01/31/17 at 1:11 PM revealed that all medication carts are to be locked when not in eye sight by the appropriate staff or nurse. The DON stated that Nurse #1 had told her that she thought she had locked the cart but when she returned to the medication cart it was unlocked. Nurse #1 also told the DON that the lock would stick sometimes and the DON instructed her to fill out a maintenance form since she had not done so previously.
Interview with the Administrator on 01/31/17 at 1:33 PM revealed that she routinely made rounds and checked for medication carts that were unlocked and unattended. The administrator stated she expected the medication carts to be locked when not attended by the appropriate staff.

F 431

reported the violation to the DON, who coached the nurse on the importance of locking the med cart.

The nurse claimed she had pushed the lock, but it failed to lock because it had been "sticking". Maintenance checked the lock on 1-31-17 and reported the lock to be working properly.

3) At the next nurses meeting on 2-20-17, the DON will re-educated nurses and med aides on the importance of locking carts when they are not at the med cart or within sight of the med cart. Staff unable to attend the training will be required to see the ADON no later than 2-28-17 for a one-on-one in-service and review.

Also, the SDC will educate all new hires during orientation on medication administration, which will include locking the med carts.

4) The administrator or designee will complete weekly random audits on all SN halls for the next 4 weeks. If a med cart is found unlocked and unattended, the administrator or designee will notify the DON, who will then issue a disciplinary warning to the staff involved.

Results from the audit will be shared and reviewed during QAPI meetings for tracking and trending purposes with follow up action taken as needed. Monitoring will be ongoing.

All corrective action will be completed by

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F 431	Continued From page 7	F 431	2-28-17.	