STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(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 An unannounced complaint investigation survey was conducted on 9/18/24 through 9/19/24. Event ID# 8HD811. The following intake was investigated NC00222045. One (1) of 1 complaint allegation resulted in a deficiency.	F 000		
F 760 SS=D	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 staff interviews, the facility failed to prevent a significant medication when a nurse administered 40 mg of liquid morphine when the physician order was for 5mg to 1 of 3 sampled residents (Resident #1) reviewed for medication administration. The findings included: Resident #1 was admitted to the facility on 10/24/22 with diagnoses that included Schizophrenia, Dysphagia, Depression, chronic pain, muscle spasm, and gastrostomy status (medication/nutrition through a feeding tube). The quarterly minimum data set dated 8/22/24 indicated Resident #1 had short/long term memory problems, gastrostomy status and received medication/nutrition through a feeding tube. Review of the medical record documented Resident #1's was discharged from Hospice services on 6/19/24 and code status as DNR (do	F 760	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: RESIDENT #1 WAS AFFECTED BY MEDICATION ERROR AND NO LONGER IN THE FACILITY ON-CALL MEDICAL DOCTOR INFORMED OF MEDICATION ERROR ON 9/14/24 MEDICATION ERROR REPORT COMPLETED NURSE #1 RESIGNED EFFECTIVE IMMEDIATELY Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 4 RESIDENTS HAVE THE POTENTIAL	10/1/24

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

Electronically Signed | 10/01/2024

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F 760	Continued From page 1 not resuscitate). The physicians order dated 10/27/23 revealed an order for morphine concentrate - Schedule II solution; 100 mg/5 mL (milligram/milliliter) (20 mg/mL); Amount to Administer: 0.25 mL (5MG); gastric tube. Every 6 Hours - PRN (as needed) for signs of pain or air hunger. Review of the nurses note dated 9/15/24 and written by Nurse #1 revealed during late evening close to end of shift, Resident was having facial grimacing/frowning, restlessness which Nurse #1 thought she may be experiencing pain. Nurse #1 decided to give her PRN (as needed) morphine. Resident was alert, responded to touch and voice when name was called, by giving eye contact. "As the oncoming nurse and I were counting, it seemed I had given too much morphine. The oncoming nurse began to monitor by taking vital signs, 02 (oxygen) saturation sounds, which showed she was stable. A phone interview was conducted on 9/18/24 at 11:48 AM with Nurse #1. Nurse #1 stated when counting the narcotic medications on second shift on she realized that she had given Resident #1 the wrong amount of liquid pain medication. She revealed at that time she notified Nurse #2 and she and Nurse #2 went to check on Resident #1. Nurse #2 reported Resident #1's vital signs were within normal limits, she turned towards staff when called and when touched. She reported she had observed Resident #1's facial grimaces and stiff hands as signs of pain and decided to give the prn pain medication for relief. She indicated she had reviewed the orders; the medication label was blurry, and she gave 2.5 mL of morphine instead of the 0.25 mg as ordered. Nurse #1	F 760	TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE. 100% AUDIT OF LIQUID NARCOTICS COUNT AND LABELS COMPLETED BY THE INFECTION PREVENTIONIST (IP) NURSE WITH NO DEFICIENT PRACTICE ON 9/30/24 Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. 100% EDUCATION TO ALL LICENSED NURSES ON OPIOD OVERDOSE POLICY COMPLETED BY THE INFECTION PREVENTIONIST (IP) NURSE ON 10/1/24. ANYONE NOT RECEIVING EDUCATION DUE TO FMLA OR SCHEDULED TIME OFF WILL RECEIVE EDUCATION BEFORE NEXT SCHEDULED SHIFT. 100% EDUCATION TO ALL LICENSED NURSES ON 5 RIGHTS OF MEDICATION ADMINISTRATION/OPIOD TOXICITY/WHO TO CONTACT BY THE DIRECTOR OF NURSING (DHS) COMPLETED 9/19/24. ANYONE NOT RECEIVING EDUCATION DUE TO FMLA OR SCHEDULED TIME OFF WILL RECEIVE EDUCATION BEFORE NEXT SCHEDULED SHIFT. 100% EDUCATION ON WHAT TO DO WITH BLURRY MEDICATION LABEL COMPLETED BY THE DIRECTOR OF NURSING (DHS) 9/19/24. ANYONE NOT RECEIVING EDUCATION DUE TO FMLA	

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F 760	Continued From page 2 indicated she had been distracted, and Resident #1 was not her usual assignment when she gave the wrong dose of pain medication. In a phone interview on 9/18/23 at 11:18 AM Nurse #2 revealed on 9/14/24 she and Nurse #1 were counting the controlled narcotics, when Nurse #1 indicated she had given Resident #1, 2.25 mL verses the prescribed 0.25 mg of morphine. Nurse #1 indicated she had checked the physician order and when she got the medication out the label was blurry and the amount looked like a whole number, (Two) to her. Nurse #2 revealed they immediately checked on Resident #1. Her vital signs (VS) were within normal limits and she responded to her name when called. Nurse #2 revealed that the resident's VS were normal, and she was responding, she would continue to monitor the resident and notify the physician if there was any change. Nurse #2 indicated she notified the On-Call Medical Doctor that Resident #1 had received more liquid morphine than prescribed. In an interview on 9/18/23 at 12:38 PM the Director of Nursing (DON) revealed staff called her on 9/14/24 to notify her Resident #1 had received a medication error. Review of the Controlled Drug Record dated 9/14/24 at 10:00 PM documented Resident #1 received 2.25 mL of morphine on 9/14/24. On 9/19/23 the Director of Nursing completed a medication error report for Resident #1. The medication error report was completed for a resident who received 2.25 mL of morphine when the ordered dose was 0.25 mL.	F 760	OR SCHEDULED TIME OFF WILL RECEIVE EDUCATION BEFORE NEXT SCHEDULED SHIFT. EDUCATION TO BE PROVIDED BY IP NURSE TO ALL NEW NURSES IN ORIENTATION MOVING FORWARD ON OPIOD OVERDOSE POLICY, 5 RIGHT OF MEDICATION ADMINISTRATION, WHO TO CONTACT AND WHAT TO DO WITH A BLURRY MEDICATION LABEL(S) WILL BE CONDUCTED BY THE DIRECTOR OF NURSING (DHS) OR DESIGNEE Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. - DHS OR DESIGNEE TO PERFORM MEDICATION ADMINISTRATION ACCURACY AUDIT, LIQUID NARCOTIC COUNT ACCURACY AUDIT AND LIQUID NARCOTIC LABEL CLARITY AUDIT - 5 DAYS PER WEEK X 4 WEEKS - 3 DAYS PER WEEK X 4 WEEKS - WEEKLY X 4 WEEKS - CONSULTING PHARMACIST TO PERFORM 1 RANDOM AUDIT MONTHLY - DHS TO REPORT FINDINGS TO QAPI MONTHLY FOR 3 MONTHS - QAPI COMMITTEE TO DETERMINE IF ONGOING MONITORING IS NEEDED Date of compliance: 10/1/2024	

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F 760	Continued From page 3 In an interview on 9/19/24 at 1:51PM the DON revealed the morphine bottle had measurements on the side of bottle, with a blue line to indicate the amount of liquid in Resident #1's 30 mL bottle. The DON revealed she filed a Medication Error report as Resident #1 received 2.25 mL of morphine when the order was for 0.25 mL. The DON stated Resident #1 did not receive 6.25 mL of morphine she was administered 2.25 mL. Observation of Resident #1's morphine bottle on 9/19/24 at 1:53 PM with the DON revealed 28.0 cc of morphine in the bottle.	F 760		