

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>345551</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>08/27/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>PRUITTHEALTH-CAROLINA POINT</b>		STREET ADDRESS, CITY, STATE, ZIP <b>5935 MOUNT SINAI ROAD DURHAM, NC 27705</b>	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0760  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Few</b>	<p><b>Ensure that residents are free from significant medication errors.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on record review and staff interviews, Pharmacy Manager interview, and Nurse Practitioner interview the facility failed to provide all prescribed medications to 1 of 5 sampled residents (Resident #1) for up to four doses by not securing and administering ordered medications following resident's admission into the facility. The findings included: Resident #1 was admitted on [DATE] with a [DIAGNOSES REDACTED]. Record review of Resident #1's most recent minimum data sheet (MDS) assessment, dated 8/4/2020, revealed Resident #1 is assessed as severely cognitively impaired. She requires assistance from staff to provide total care with dressing, bathing, transfers, and personal hygiene. Resident #1 is unable to verbalize her needs to staff. Review of Medication Administration Record [REDACTED]. [MEDICATION NAME] for blood pressure was missed on 8/1/2020 at 9 AM; 2. [MEDICATION NAME] for pneumonia were missed on 7/31/2020 at 9 PM, 8/1/2020 at 9 AM and 9 PM; 3. [MEDICATION NAME] drops 0.2% for [MEDICAL CONDITION] were missed on 7/31/2020 at 9 PM, 8/1/2020 at 9 AM, 2 PM, and 9 PM; 4. [MEDICATION NAME]-[MEDICATION NAME]-entacapone for [MEDICAL CONDITION] were missed on 7/31/2020 at 9 PM, 8/1/2020 at 9 AM, 2PM, and 9 PM; 5. Dorzolamide drops 2% for [MEDICAL CONDITION] were missed on 7/31/2020 at 9 PM and 8/1/2020 at 9 PM; 6. Entacapone for [MEDICAL CONDITION] were missed on 7/31/2020 at 9 PM, 8/1/2020 at 9 AM, 2 PM, and 9 PM; 7. Krill Oil for health promotion was missed on 8/1/2020 at 9 AM 8. Lantanoprost drops for [MEDICAL CONDITION] was missed on 8/1/2020 at 9 AM, 9. [MEDICATION NAME] for [MEDICAL CONDITION] was missed on 8/1/2020 at 6 AM, 10. [MEDICATION NAME] for depression were missed on 7/31/2020 at bedtime, and 8/1/2020 at bedtime. 11. [MEDICATION NAME] for acid reflux were missed on 7/31/2020 at 9 PM, and 8/1/2020 at 9 PM An interview with Nurse #1 on 8/25/2020 at 9:49 AM, revealed newly admitted residents may miss one dose of medication, but usually it is just a little late and not missed. The facility has medications available for dispensing at the facility in the automatic medication dispensing system for staff to use when resident's medications are unavailable. There is a local pharmacy available to deliver medications within hours to meet resident needs. An interview with Nurse #2 on 8/26/2020 at 12:37 PM, revealed she worked on the evening of 7/31/2020 when Resident #1 was admitted to her unit. Staff did not remember contacting the pharmacy to discuss Resident #1's evening admission. She stated her coworkers on the unit and herself were unsure where to locate the pharmacy's contact information. Staff verbalized she was unaware there was an automated medication dispensing system stocked with the facility's commonly used medications available on a different hallway in the facility. Staff revealed she did not contact the nurse practitioner and inform her Resident #1's medications were not administered during her shift. Nurse #3 was interviewed on 8/26/2020 at 1:03 PM, revealed there is an emergency kit available at the facility. In this emergency kit there is medication available to administer to residents in the event a medication has been ordered by a physician and the facility's contracted pharmacy has not had time to deliver the prescription to the facility. If staff is unable to administer any medication to a resident, the nurse practitioner should be notified. Interview with Pharmacy Manager on 8/26/2020 at 3:26 PM, revealed the phone line recording for incoming calls on 7/31/2020 was reviewed, and it was discovered no message were left from facility regarding Resident #1 coming in as a late admission on 7/31/2020; this prevent Resident #1 medications from being included in the evening delivery. Pharmacist stated there is an automatic medication dispensing system at the facility that allows staff to access commonly used medications. The machine's inventory was reviewed for the dates of 7/31/2020 and 8/1/2020, the following medications were available at the facility for administration: [MEDICATION NAME], Lantanoprost, [MEDICATION NAME], and [MEDICATION NAME]. Pharmacy Manager stated a local back-up pharmacy can be available to deliver medications to the facility within hours of notification to meet resident needs. An interview with Nurse Practitioner (NP) #1 on 8/26/2020 at 4:31 PM, revealed if staff is unable to administer any medications to a resident, the staff is required to report this information to the NP. NP revealed there have been cases when a medication is not available due to shortages. When staff notifies NP of this obstacle, the order will be changed to a comparable medication that is available to facility. Staff did not notify the NP at any time about Resident #1 missing doses of ordered medications. The Interim Director of Nursing was interviewed on 8/26/2020 at 4:28 PM, revealed staff has not voiced any concerns regarding medications not being accessible for administration to residents. Staff also states she has not heard of any resident's not receiving their prescribed medications at the date and time they are due. An interview with Clinical Competency Coordinator on 8/27/2020 at 8:57 AM, revealed during new staff orientation facility policies and procedures are discussed. Staff are also given a tour of the facility, including the location of the automatic medication dispensing system and receive a code to access the unit. Clinical Competency Coordinator also stated staff members have access to an on-call personal if assistance is needed during nights and weekend shifts. An interview with acting Administrator on 8/27/2020 at 11:29 AM, revealed he has not heard any concerns from staff about not having prescribed medications to administer to residents. Medications commonly ordered by our physicians can be found in the automatic medication dispensing system located in our facility. If a resident needs a medication not available in the automatic medication dispensing system, the pharmacy will be contacted to meet this need.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.