STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

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 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Nurse Practitioner (NP) interviews the facility failed to ensure that a resident's drug regimen was free from unnecessary drugs and laboratory test were collected as ordered by the NP for 1 of 4 residents (Resident #7) whose medications were reviewed. Findings included: Resident #7 was admitted to the facility on [DATE] and passed away on 07/31/20. Resident #7 had [DIAGNOSES REDACTED]. The April, May, and June 2020 physician orders [REDACTED].#7. The June 2020 Medication Administration Record (MAR) revealed a handwritten entry for K-DUR (a potassium supplement) 20 meq (milliequivalents) 2 = 40 meq po (by mouth) daily take with food. The date of the order was handwritten as 04/21/20 and the time to be dispensed was 8:00 AM. There were five sets of initials on the June 2020 MAR signifying that Resident #7 received the K-DUR 06/02/20, 06/05/20, 06/06/20, 06/07/20 and 06/10/20. The Health Status Note dated 06/11/20 at 2:13 PM and written by the previous Director of Nursing (DON), revealed Resident #7's family and physician had been made aware Resident #7 had been administered five doses of a medication without a physician's orders [REDACTED]. The physician's orders [REDACTED]. There was no mention of the medication error or of any adverse effects in the Health Status notes after 06/11/20 at 2:13 PM through 06/15/20. The order for the CMP, which was signed off by the previous DON was not collected until 06/15/20 at 8:00 AM and revealed a Potassium level of 4.1 mmol/L (millimoles per liter) which was within the normal reference range of the test. In a telephone interview on 08/05/20 at 5:22 PM the previous DON stated there was a transcription error and another resident's order was placed on Resident #7's June 2020 MAR. She was unable to remember the name of the resident who should have gotten the K-DUR. The previous DON stated that Resident #7's potassium level had been checked but she did not know why it had not been done on the date ordered. In a telephone interview on 08/06/20 at 12:25 PM Nurse #10 stated that she was the one who discovered the K-DUR handwritten order on Resident #7's June 2020 MAR and that there was no order for the medication from the physician. She indicated she informed the previous DON and the medication was discontinued. In an interview on 08/06/20 at 1:35 PM Nurse #5, Weekend Supervisor, stated that initials in the box for a medication meant the medication was given. In a telephone interview on 08/07/20 at 10:17 AM Nurse #11, who was assigned to Resident #7 on 06/05/20 and 06/10/20, confirmed that she was the nurse who made the transcription error and placed the order for K-DUR on Resident #7's June 2020 MAR. Nurse #11 indicated that if a medication was on the MAR, she would give the medication and initial the box that showed she gave it. She denied that she gave Resident #7 any K-DUR even though her initials were in the box on the MAR signifying she administered the medication on 06/05/20 and 06/10/20 to Resident #7. In a telephone interview on 08/07/20 at 12:17 PM Nurse #12, who was assigned to Resident #7 on 06/02/20, 06/06/20 and 06/07/20, stated that if the K-DUR was on the MAR, and her initials were in the box, then she gave Resident #7 the K-DUR. She indicated that she worked on different halls and did not know Resident #7 well enough to question the K-Dur. In a telephone interview on 08/10/20 at 11:56 AM the NP stated she remembered being informed of the medication error for Resident #7 and that she had ordered laboratory tests. The NP stated that although she did not order it to be done, she would have expected Resident #7's blood pressure and heart rate to be monitored and neurological checks to be performed every shift for the 72 hours following the discovery of the medication error. The NP stated that she also remembered that the CMP was not drawn as she had ordered and that due to the delay in the lab draw, she was unsure of the true level of the serum potassium for the time in question. She indicated that she expected her orders to be followed and that labs be drawn timely because the results could be less accurate if they were not. The NP indicated that due to the COVID pandemic she was not able to go into the facility to exam Resident #7. In a telephone interview on 08/10/20 at 1:30 PM the Interim Director of Nursing (DON) indicated that she was not at the facility when the medication error occurred and could not speak to specifics about the error. She indicated that, in general, if a medication error was identified she would expect an investigation to be done at the time the error was discovered to include vital signs and assessments of the resident for the 72 hours to a week following the error depending on the medication. She would also expect contact with the pharmacist to check for drug interactions and allergies [REDACTED]. She also expected that labs be drawn as ordered and not delayed.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 2 of 2 medication carts observed (100 and 200 hall medication carts). Findings included: 1. During an observation on 08/05/20 at 5:04 PM the 100 hall medication cart was against the wall between the bathroom and the medication room. The lock on the medication cart did not appear to be engaged. No staff members were seen near the medication cart. After approximately one minute Nurse #1 walked onto the 100 hall from around the corner. She confirmed that she was the nurse responsible for the medication cart. In an interview on 08/05/20 at 5:05 PM Nurse #1 verified that the medication cart was unlocked by opening a drawer containing medications without using a key to unlock the medication cart. She confirmed that she had left the medication cart unlocked and unattended while she was speaking to another staff member around the corner. Nurse #1 stated that medication carts should always be kept locked when unattended so that the medications could not be removed from the carts. In a telephone interview on 08/10/20 at 1:30 PM the Interim Director of Nursing (DON) stated that when a medication cart was not in use it needed to be locked for safety. 2. During a continuous observation on 08/06/20 from 2:25 PM-2:43 PM the 200 hall medication cart was against the wall between rooms [ROOM NUMBERS]. The lock on the medication cart did not appear to be engaged. During this time, multiple staff members walked past the unattended medication cart, including Nurse #2. When requested, Nurse #2 who was standing at the nursing station out of view of the medication cart, walked to the medication cart and confirmed he was the nurse responsible for the medication cart. In an interview on 08/06/20 at 2:43 PM Nurse #2 verified that the medication cart was unlocked by opening a drawer containing medications without using a key to unlock the medication cart. Nurse #2 stated that he had left the medication cart unlocked and unattended in error and that he should have made sure the cart was locked. He indicated that the purpose of locking the cart was to make sure that no one could remove medications from the cart. In a telephone interview on 08/10/20 at 1:30 PM the Interim Director of Nursing (DON) stated that when a medication cart was not in use it needed to be locked for safety.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and review of the facility's Linen Handling policy, the facility failed to implement their Linen Handling policy by not placing dirty linens in a bag and then placing the linens in a container for 1 of 2

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident hallways observed (200 hallway). Findings included: Review of the facility Linen Handling Policy, dated 03/10/20, for soiled linens documented, Soiled linen should be handled as little as possible and with minimum agitation to prevent microbial contamination of the air and of staff handling the linen. Soiled linen should be bagged or placed in containers at the location where it is used. On 08/05/20 from 9:35 AM to 10:55 AM visibly soiled bath towels were observed to be wadded up on a folding chair sitting on the 200 hallway between rooms [ROOM NUMBERS]. Multiple staff members walked past the soiled linens during the observation period and did not remove it until 10:55 AM, when it was brought to the attention of Nurse #2. In an interview conducted with Nurse #2 on 08/05/20 at 10:55 AM he stated soiled linen should not have been sitting open on a chair in the hallway. He said soiled linen was supposed to be bagged before leaving a resident room and taken directly to the soiled linen room. He took the soiled linen to the soiled linen room and counted 4 visibly soiled towels that had been left wadded up on the chair in the hallway between rooms [ROOM NUMBERS]. In an interview conducted with Nurse Aide #3 on 08/05/20 at 11:15 AM she stated she was assigned to work on the 200 hall. She remarked she had not noticed the dirty linens sitting on the chair in the hallway. She was taught by the facility to bag dirty linens before leaving a resident room and take it to the soiled linen room. She stated she had not left the soiled linens sitting on the chair. In an interview conducted with Nurse Aide #4 on 08/05/20 at 11:30 AM she stated she was working on the 200 hall. She said she had not placed any soiled linens on a chair in the hallway. She remarked she was working at the facility through an agency. She stated she put dirty linens in a bag before leaving a room and took the bag to the soiled linen room to place in a bin. In an interview conducted with Nurse Aide #5 on 08/05/20 at 11:50 AM she stated she was assigned to work on the 200 hall and that it was her first day at the facility. She said she put soiled linen in a bag while in the room, sat it on the floor until finished then took it to the soiled linen room. She commented she had taken all her soiled linens to the soiled linen room and had not noticed the dirty towels in the hallway. In an interview with the Director of Nursing on 08/05/20 at 3:15 PM she commented it was her first day at the facility, but was familiar with the facility policies. She knew the nurse aides were trained to bag soiled linens in a resident's room and then take it directly to the soiled linen room. She would not expect to see soiled linens sitting open on a chair in a hallway. She commented along with being a dignity issue it was also an infection control issue. She remarked any resident with cognition problems could have wrapped themself in the dirty linen not knowing what it was.