STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015460	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHARLTON PLACE REHAB AND HEALTHCARE CENTER	**65 CHARLTON PLACE DEATSVILLE, AL 36022**

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 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, medical record reviews, and review of the facility policy titled Administering Medications, the facility failed to ensure the medications error rate was less than five percent. During medication administration observations from 3/11/20 through 3/12/20 two errors were observed out of twenty-five total opportunities, equaling a medication error rate of eight percent. This affected Resident Identifier (RI) #4 and RI #59, two of three residents observed for medication pass. Findings Include: A facility policy titled Administering Medications, revised December 2012, revealed: Policy Statement Medications shall be administered . as prescribed. . 3. Medications must be administered in accordance with the orders . 7. The individual administering the medication must . verify the . right medication .before giving the medication. . RI #4 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. On 3/11/20 at 9:40 a.m., an observation was made of Employee Identifier (EI) #5, Licensed Practical Nurse (LPN), administering medication to RI #4 from the Station Two Medication Cart. EI #5 administered Senna Plus, containing 50 milligrams (mg) [MEDICATION NAME] sodium and 8.6 mg sennosides, to RI #4. However, when reconciling the medications administered to RI #4 by EI #5 with the physician's orders, it was noted that RI #4's Order Summary Report listed an active order with a Start Date of 9/14/2019 for [MEDICATION NAME] Tablet 8.6 milligrams (mg) (Sennosides) Give 8.6 mg by mouth one time a day for constipation. There was no order for the Senna Plus. RI #59 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. On 3/11/20 at 4:28 p.m., an observation was made of EI #6, LPN, administering medications to RI #59 from the Rehab Medication Cart. EI #6 administered Senna Plus, containing 50 mg [MEDICATION NAME] sodium and 8.6 mg sennosides, to RI #59. However, when reconciling the medications administered to RI #59 by EI #6 with the physician's orders, it was noted RI #59's Order Summary Report listed an active order with a Start date of 2/22/2020 for Senna Tablet 8.6 MG (Sennosides) Give one (1) tablet via PE[DEVICE] (Percutaneous Endoscopic Gastrostomy Tube) two times a day for Constipation. There were no active orders for Senna Plus or [MEDICATION NAME] sodium. On 3/12/20 at 12:09 p.m., an interview was conducted with EI #7, Registered Nurse (RN). EI #7 was asked, what the active ingredients listed on the bottle of medication in which Sennosides or Senna was administered. EI #7 found the bottle and stated, the bottle was labeled Senna Plus and contains sennosides 8.6 mg and [MEDICATION NAME] 50 mg. EI #7 was asked, when sennosides 8.6 mg and [MEDICATION NAME] 50 mg were administered when sennosides 8.6 mg tablet was ordered, what did she call that. EI #7 replied, it was a medication error. On 3/12/20 at 12:19 PM, EI #8, LPN, was asked to check the Rehabilitation Medication Cart. EI #8 was asked, when Sennosides 8.6 mg is ordered, what bottle was used. EI #8 replied, Senna Plus. EI #8 was asked, what were the active ingredients in Senna Plus. EI #8 replied, sennosides 8.6 mg and [MEDICATION NAME] 50 mg. EI #8 was asked, when sennosides 8.6 mg and [MEDICATION NAME] 50 mg were administered when sennosides 8.6 mg tablet was ordered, what did she call that. EI #8 replied, it would be a medication error. On 3/12/20 at 12:27 PM, an interview was conducted with EI #2, RN/Director of Nursing. EI #2 was asked, what was [MEDICATION NAME] sodium. EI #2 replied, in a facility like this it was a medication. EI #2 was asked, did administration of [MEDICATION NAME] sodium at a skilled nursing facility require a physician's order. EI #2 replied, yes. EI #2 was asked, when sennosides 8.6 mg was ordered, and then [MEDICATION NAME] sodium 50 mg with sennosides 8.6 mg was administered, what was that called. EI #2 replied, a medication error. EI #2 was asked, why was that a medication error. EI #2 replied, because something was being administered that was not ordered. EI #2 was asked, who was responsible for administering medications as ordered. EI #2 replied, the nurses.

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.