STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345225	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF CHAPEL HILL	1602 E FRANKLIN STREET CHAPEL HILL, NC 27514

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, attending physician, consultant pharmacist and corporate representative interviews the facility failed to document a scheduled dose of an intravenous antibiotic ([MEDICATION NAME]) had been administered to Resident #2, which resulted in an extra dose of the medication being administered to her. This was evident for 1 of 3 residents reviewed for medication errors. Findings included: Resident #2 was admitted to the facility on [DATE] with cumulative [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS)dated 3/9/20 revealed a Brief Interview for Mental Status score of 15 which indicated Resident #2 was alert and oriented. Record review revealed on admission physician orders [REDACTED]. The scheduled times for administration were 6:00 AM, 2:00 PM and 10:00 PM. Review of the nurses' progress dated 03/27/2020 at 9:02 PM and authored by Nurse #2 indicated Resident #2 was administered [MEDICATION NAME] 2 grams at 6:30pm instead of 10pm. (Dose to soon). The attending physician was contacted and instructed to hold the 10:00 PM dose on 3/27/20 and resume the normal administration schedule in the morning. Record review of the Medication Error Report (MER) dated 3/27/20 revealed the description of the error began on 3/27/20 when Nurse #2 administered [MEDICATION NAME] via the PICC line at 6:30 PM. Nurse #3 (oncoming nurse) was notified to hold the 10:00 PM dose then resume the normal schedule in the morning. The MER also indicated Resident #2 told the nurse she had received her earlier dose (referring to the 2 PM scheduled dose) after [MEDICATION NAME] administered at 6:30 PM had infused. Interview on 6/15/20 at 1:57 PM with Resident #2 stated the nurse (could not remember name) gave me more antibiotic in my PICC line then the doctor ordered. Resident #2 stated she told the nurse she was administered her 2 PM dose already, but the nurse still administered the [MEDICATION NAME]. Interview on 6/15/20 at 2:15 PM with Nurse #2 stated the medication error incident occurred when she was checking the Medication Administration Record (MAR) to see whether Nurse #1 (who was in orientation) had administered all the scheduled medications. Nurse #2 noticed that the MAR was not signed/initialed that indicated [MEDICATION NAME] had been administered and took for granted Resident #2 had not received the antibiotic, so I administered [MEDICATION NAME] via the PICC line. Continued interview with Nurse #2 stated she never should have taken for granted that because the MAR was not signed Resident #2 had not been administered the 2 PM dose of [MEDICATION NAME]. Nurse #2 stated she had not attempted to communicate with Nurse #1 to verify whether the 2:00 PM [MEDICATION NAME] had been administered and just not documented as administered. Nurse #2 indicated she reported the error to the Director of Nurses (DON), took Resident #2's vital signs then notified the physician, who stated to hold the 10 PM dose. Interview on 6/15/20 at 2:30 PM with the DON stated because of the medication error incident, 1:1 training was done with Nurse #2 to validate whether medications had been administered. Interview via phone on 6/16/20 at 10:30 AM with Nurse #1 stated she administered the PICC line antibiotic but did not document as administered. During the interview Nurse #1 did not state why she failed to document the medication administration. Interview via the phone on 6/16/20 at 12:24 PM with the attending physician expressed no concerns about the [MEDICATION NAME] given as an additional dose. Interview via phone on 6/17/20 at 11:15 AM with the consultant pharmacist stated the life of [MEDICATION NAME] was 2 hours and by 6:30 PM most of the medication had cleared out of the resident's system. Half-life refers to how long it takes for half of the dose of medication to be metabolized and eliminated from the bloodstream. Interview via phone on 6/17/20 at 12:10 PM with the Administrator, DON and Corporate Representative (CR) was conducted. The DON stated it was a human error that occurred when the [MEDICATION NAME] dose (2 PM) was not documented on the MAR as administered and a second dose was administered. CR stated Nurse #1 should have documented that the [MEDICATION NAME] was administered, and Nurse #2 should have validated whether the 2 PM dose had been administered.

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.