STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews and Nurse Practitioner (NP) interview, the facility failed to prevent a significant medication error resulting in the resident's decreased respiration, receiving emergency medication ([MEDICATION NAME]) and was sent to the hospital emergency department for evaluation for 1 (resident #1) of 4 residents reviewed. Findings Included: Resident #1 was admitted to the facility on ,[DATE] with [DIAGNOSES REDACTED]. A review of the quarterly minimum data set ((MDS) dated [DATE] revealed resident #1 was severely cognitively impaired, non-verbal and required 2 person assist with activities of daily living (ADL), transfers and bed mobility. A physician's orders [REDACTED]. This order was discontinued on 05/24/2020. An order by the physician dated 05/28/2020 indicated an active order for [MEDICATION NAME] Solution 200mg/20ml, give 15ml via [DEVICE] every 12 hours for [MEDICAL CONDITION]. A review of the progress notes dated 06/08/2020 indicated the nurse administered [MEDICATION NAME] 15ml instead of the [MEDICATION NAME] 15ml in which the nurse practitioner (NP) was then informed of the medication error. The NP indicated to monitor the resident's vital signs every 15 minutes. A further review of the progress notes dated 06/08/2020 indicated the resident's respirations began to decrease to 6 breaths per minute and an oxygen saturation was 88% on 2 liters of oxygen. The NP was informed, and a verbal order was given to administer [MEDICATION NAME] 0.4mg=1ml via intramuscular injection to the left deltoid. The order was carried out and the resident's oxygen saturation increased to 98% on 2 liters of oxygen. The NP then gave a verbal order to transfer the resident to the hospital for evaluation. A review of Hospital emergency room records dated 06/08/2020 indicated resident #1 arrived at 3:58pm on 4 liters of oxygen with an oxygen saturation of 98% and 16 breaths per minute. Further review indicated basic laboratory tests and electrocardiogram was completed and no further medical interventions preformed. resident #1 was transferred back to the facility on [DATE] at 11:56pm. An interview with the Nurse #1 on 07/28/2020 at 12:35pm revealed that she mistakenly administered the [MEDICATION NAME] instead of the [MEDICATION NAME]. Upon realizing the medication error, she immediately called the NP and informed the Assistant Director of Nursing (ADON). The nurse indicated she continued to monitor the resident every 15 minutes per the order and when the resident #1 respirations decreased, she called the NP and received an order for [REDACTED]. The NP indicated she was informed via telephone of the nurse medication error and recalls giving verbal order to monitor the resident vital signs every 15 minutes. The NP further revealed receiving a call regarding the resident decreasing oxygen saturation in which it was decided to transfer the resident to the hospital for further evaluation. The NP indicated that it was likely the [MEDICATION NAME] that caused resident #1 to have a decrease in respirations and oxygen saturation resulting in the need to be transferred to the hospital. A telephone interview on 07/29/2020 at 2:08pm with the former Director of Nursing (DON) revealed the nurse informed her of the medication error. The DON further revealed resident #1 was transferred to the hospital after calling the NP. An interview with the administrator on 07/28/2020 at 12:40pm indicated when nurse #1 informed the ADON about the medication error they made sure the resident was safe and care for and a plan of correction was made for proper medication administration.

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