STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wadesboro Health & Rehab Center	2051 Country Club Road Wadesboro, NC 28170

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281 Based on record review, Consultant Pharmacist, and physician interviews, the Consultant Pharmacist failed to provide recommendations when the facility failed to follow admission orders for warfarin (a blood thinning medication used to prevent stroke) for Resident #1, which resulted in Resident #1 missing 8 doses of warfarin (4/10, 4/11, 4/12, 4/13, 4/14, 4/15, 4/16 and 4/17/2024). This was for 1 of 3 residents reviewed for medication errors. The findings included: The hospital discharge instructions dated 4/10/2024 ordered warfarin 2.5 milligrams to be given daily except for Tuesday and Thursday. Resident #1 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation and hypertension. The admission Minimum Data Set, dated dated dated [DATE] assessed Resident #1 to be severely cognitively impaired. The MDS did not document Resident #1 was taking anticoagulant medications. A nursing note written by the Assistant Director of Nursing (ADON) dated 4/10/2024 documented the ADON called the hospital to clarify the warfarin order. Review of Resident #1's medical record revealed no order for warfarin was written or in the medical record. A pharmacist consultation note dated 4/16/204 was reviewed and the note did not indicate warfarin had not been transcribed from the hospital discharge orders. The note indicated recommendations had been made for a topical cream and an antipsychotic medication. Review of the medication administration record revealed Resident #1 did not receive 8 doses of warfarin (4/10, 4/11, 4/12, 4/13, 4/14, 4/15, 4/16 and 4/17/2024). (continued on next page)

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician was interviewed on 5/14/2024 at 2:14 PM. The physician explained she was conducting a chart review of Resident #1 on 4/17/2024 and discovered the warfarin order from the hospital on 4/10/2024 had been clarified by the ADON, but an order had not been entered into the electronic charting system. The physician reported she called the Director of Nursing (DON) and reported the error and ordered warfarin for Resident #1 on 4/17/2024The physician reported Resident #1 did not experience any adverse effects from not taking the warfarin for 8 days. The Consultant Pharmacist was interviewed by phone on 5/14/2024 at 3:54 PM. The Pharmacist reported when the facility had a new admission, she reviewed the discharge hospital orders and checked those orders against the orders entered in the electronic documentation system. The Pharmacist reported she did not specifically recall reviewing Resident #1's hospital discharge orders. The Pharmacist explained the facility had changed electronic documentation systems and the hospital discharge orders had not been scanned into the system on 4/16/2024 when she reviewed Resident #1's medications. The DON was interviewed on 5/14/2024 at 4:22 PM. The DON reported she was not aware the Consultant Pharmacist was unable to review Resident #1's hospital discharge orders when she reviewed her admission records.

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(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 - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281 Based on record review, staff, Nurse Practitioner, and physician interviews, the facility failed to follow an order for warfarin (a blood thinner used to prevent stroke in a patient with atrial fibrillation [an abnormal heart rhythm]) (Resident #1) and failed to follow a physician order from a physician consultation visit for a blood pressure medication (Resident #2) for 2 of 3 residents reviewed for significant medication errors. Resident #1 did not receive 8 doses of warfarin, and Resident #2 did not receive 23 doses of blood pressure medication. The findings included: 1. The hospital discharge instructions for Resident #1 dated 4/10/2024 ordered warfarin 2.5 milligrams to be given daily except for Tuesday and Thursday. Resident #1 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation and hypertension. The admission Minimum Data Set (MDS) dated [DATE] assessed Resident #1 to be severely cognitively impaired. The MDS did not document Resident #1 was taking anticoagulant medications. A nursing note written by the Assistant Director of Nursing (ADON) dated 4/10/2024 documented the ADON called the hospital to clarify the warfarin order. Review of Resident #1's medical record revealed no order for warfarin was written or in the medical record. Review of the medication administration record revealed Resident #1 did not receive 8 doses of warfarin (4/10, 4/11, 4/12, 4/13, 4/14, 4/15, 4/16 and 4/17/2024). Resident #1 was admitted to the hospital on 4/17/2024. The emergency room notes dated 4/17/2024 documented Resident #1 was admitted for an irregular heart rate and change in mental status. emergency room notes dated 4/17/2024 ordered lab work to check the efficiency of warfarin. The prothrombin time (PT) was 14.3 (normal range 11.8 to 14.4) and the International Normalized Ratio (INR) 1.1 (therapeutic range 2. 0-3.0). This test determines if the warfarin is in therapeutic range. The notes documented the PT/INR was sub-therapeutic and Resident #1 was started on an injectable blood thinner. Resident #1 returned to the facility on [DATE]. Physician orders for Resident #1 revealed an order dated 4/18/2024 for apixaban (a blood thinner) 2.5 milligrams to be given 2 times per day. A physician note dated 4/23/2024 documented Resident #1 was discharged from the hospital on 4/18/2024 and warfarin was discontinued and apixaban was initiated. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the ADON on 5/14/2024 at 2:04 PM. The ADON explained she was helping the Unit Manager (UM) with the admission of Resident #1 on 4/10/2024. The ADON reported the warfarin order was not clear, and she had called the hospital to talk to the discharging physician and she received clarification of the order. The ADON explained she had told the UM the clarified order for the warfarin and she thought the UM had entered the warfarin orders into the system. The ADON said that she was not aware Resident #1 had not received warfarin since 4/10/2024 until she was admitted to the hospital on 4/17/2024. The physician was interviewed on 5/14/2024 at 2:14 PM. The physician explained she was conducting a chart review of Resident #1 on 4/17/2024 and discovered the warfarin order from the hospital on 4/10/2024 had been clarified by the ADON, but an order had not been entered into the electronic charting system. The physician reported she call the Director of Nursing (DON) and reported the error and ordered warfarin for Resident #1 on 4/17/2024, but Resident #1 was sent to the hospital for an irregular heart rate and a change in her mental status. The physician explained she consulted with the emergency department physician, and they recommended apixaban for Resident #1. The physician reported that when Resident #1 returned to the facility, they started the apixaban. The physician stated that a blood thinner was used for stroke prevention in patients with atrial fibrillation. The physician reported Resident #1 did not experience any adverse effects from not taking the warfarin for 7 days. The UM was interviewed on 5/14/2024 at 2:35 PM. The UM explained he was the floor nurse when Resident #1 was admitted , and he and the ADON worked together to enter Resident #1's orders into the electronic documentation system. The UM said he had not understood the warfarin order for Resident #1 and had asked the ADON to call the hospital to get clarification. The UM reported the ADON had received clarification and he thought the ADON had entered the order into the system. The UM said that typically, during the morning meeting each day, the staff would review the admission charts for accuracy, but that did not happen with Resident #1 and that was why the warfarin order was missed. An interview with the DON was conducted on 5/14/2024 at 4:22 PM. The DON reported the morning meeting review of Resident #1's admission did not occur because the facility had just gone live with a new electronic documentation system and the process was not followed. The DON reported when the physician discovered the medication error, the facility immediately reviewed new admissions from the past 30 days and put a plan of correction in place to prevent future errors. The DON reported she expected the nurses to check behind each other and not assume someone else entered orders into the electronic documentation system and for the daily morning meeting to review all new admission orders against the electronic documentation system. 2. Resident #2 was admitted to the facility on [DATE] with diagnoses including congestive heart failure and diabetes. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #2 was cognitively intact. A nephrology (kidney doctor) note and physician order dated 3/25/2024 ordered amlodipine (a blood pressure medication) 10 milligrams to be administered 1 time per day. The physician orders for Resident #2 were reviewed. An order dated 3/29/2024 ordered amlodipine 5 milligrams to be administered 1 time per day. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication administration record revealed Resident #2 did not receive 23 doses of amlodipine 10 milligrams (3/26, 3/27, 3/28, 3/29, 3/30, 3/31, 4/1, 4/2, 4/3, 4/4, 4/5, 4/6, 4/7, 4/8, 4/9, 4/10, 4/11, 4/12, 4/13, 4/14, 4/15, 4/16, 4/17/2024). Review of Resident #2's blood pressure results revealed the following: 3/7/2024 120/81 (normal) 4/3/2024 118/83 (normal) A physician note dated 4/2/2024 was reviewed. The physician note documented review of Resident #2's blood pressure results and noted consultations with psychiatry and optometry, but no mention was made of the nephrology consultation. The physician note documented Resident #2 was taking amlodipine 5 milligrams 1 time per day. A nurse practitioner note dated 4/16/2024 documented his diagnoses of hypertensive heart disease with kidney failure and noted his medication amlodipine 5 milligrams 1 time daily. The note documented need for cardiology and nephrology referrals. A physician order dated 4/17/2024 ordered amlodipine 10 milligrams to be administered 1 time per day. An interview was conducted with the Assistant Director of Nursing (ADON) on 5/14/2024 at 2:04 PM. The ADON explained she was auditing charts after the transcription error was found on 4/17/2024 and discovered the nephrology consultation note with the order to increase Resident #2's amlodipine to 10 milligrams per day. The ADON explained that when Resident #2 returned from the nephrology appointment, he had returned with a packet and the order was in the packet, but the nurse assigned to him had not reviewed the packet. The physician was interviewed on 5/14/2024 at 2:24 PM and reported she was not aware of the medication change ordered by the nephrologist. The physician explained that the blood pressure medication was used to help the kidneys when a patient had kidney disease and he did not have adverse effects from not receiving the increase in blood pressure medication for 23 days. The nurse practitioner was interviewed by phone on 5/14/2024 at 4:10 PM. The nurse practitioner reported she was aware Resident #2 had a nephrology consultation but was not certain when she became aware of the consultation and did not know the amlodipine order was changed during the consultation. The Director of Nursing (DON) was interviewed on 5/14/2024 at 4:22 PM. The DON explained Resident #2 took a packet with him to the nephrology consult that was returned with him with the order to increase the amlodipine to 10 milligrams, but that packet was not reviewed by his assigned nurse. The DON reported a new process was implemented to include a new form sent with residents when they go out to a physician visit and staff nurses are expected to review this packet upon the resident's return to the facility. This packet included resident medication information, demographics, and a form for new orders. The DON explained the residents who go out to a physician appointment are reviewed during the morning meeting and the packet is checked against the electronic documentation system for accuracy. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility plan of correction dated 4/18/2024 was reviewed and it documented the discovery of the medication omission for Resident #1 by the physician on 4/17/2024. This error lead the facility to conduct audits on 4/17/2024 for all admissions in the past 30 days and during the audit process, it was discovered Resident #2 had a medication order from the nephrology consultant that was not transcribed into the system. A root cause analysis was conducted on 4/17/2024, and it was determined the facility failed to follow the process of using the admission check list and this resulted in the medication error for Resident #1 and the missed medication change for Resident #2. The facility audited all resident charts to check the accuracy of orders entered in to the electronic documentation system on 4/17/2024. No other errors were found. Education was provided by the DON on 4/17/2024 to the ADON, the UM, and all nursing staff related to transcriptions of orders, validation of order transcription, as well as medications that require lab monitoring. This education was provided to nurses in person or over the phone. The facility implemented an order listing report audit to be conducted 5 times per week for 12 weeks to cross reference physician orders with the electronic documentation system. New admission charts will be audited daily for validation of all medications, orders will be clarified, lab work will be obtained as needed and the orders will be checked for accuracy. An ad hoc Quality Assessment and Performance Improvement team met on 4/18/2024 to discuss the medication error and put the plan of correction in place. The facility plan of correction was validated on 5/14/2024 by reviewing the education provided to the nursing staff, reviewing the audits conducted on new admissions and residents returning from physician visits, interviewing nursing staff, the ADON, the Unit Manager, and the Director of Nursing regarding their procedures with new admissions and residents returning from physician visits. Quality Assessment and Performance Improvement ad hoc meeting notes from 4/18/2024 were reviewed. The facility plan of correction date of 4/18/2024 was validated.