STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

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** 20710 Based on record review, and staff interviews, the facility failed to prevent a significant medication when a nurse administered 40 mg of liquid morphine when the physician order was for 5mg to 1 of 3 sampled residents (Resident #1) reviewed for medication administration. The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included Schizophrenia, Dysphagia, Depression, chronic pain, muscle spasm, and gastrostomy status (medication/nutrition through a feeding tube). The quarterly Minimum Data Set, dated dated dated [DATE] indicated Resident #1 had short/long term memory problems, gastrostomy status and received medication/nutrition through a feeding tube. Review of the medical record documented Resident #1's was discharged from Hospice services on 6/19/24 and code status as DNR (do not resuscitate). The physicians order dated 10/27/23 revealed an order for morphine concentrate - Schedule II solution; 100 mg/5 mL (milligram/milliliter) (20 mg/mL); Amount to Administer: 0.25 mL (5MG); gastric tube. Every 6 Hours - PRN (as needed) for signs of pain or air hunger. Review of the nurses note dated 9/15/24 and written by Nurse #1 revealed during late evening close to end of shift, Resident was having facial grimacing/frowning, restlessness which Nurse #1 thought she may be experiencing pain. Nurse #1 decided to give her PRN (as needed) morphine. Resident was alert, responded to touch and voice when name was called, by giving eye contact. As the oncoming nurse and I were counting, it seemed I had given too much morphine. The oncoming nurse began to monitor by taking vital signs, 02 (oxygen) saturation sounds, which showed she was stable. (continued on next page)

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

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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 - Few	A phone interview was conducted on 9/18/24 at 11:48 AM with Nurse #1. Nurse #1 stated when counting the narcotic medications on second shift on she realized that she had given Resident #1 the wrong amount of liquid pain medication. She revealed at that time she notified Nurse #2 and she and Nurse #2 went to check on Resident #1. Nurse #2 reported Resident #1's vital signs were within normal limits, she turned towards staff when called and when touched. She reported she had observed Resident #1's facial grimaces and stiff hands as signs of pain and decided to give the prn pain medication for relief. She indicated she had reviewed the orders; the medication label was blurry, and she gave 2.5 mL of morphine instead of the 0.25 mg as ordered. Nurse #1 indicated she had been distracted, and Resident #1 was not her usual assignment when she gave the wrong dose of pain medication. In a phone interview on 9/18/23 at 11:18 AM Nurse #2 revealed on 9/14/24 she and Nurse #1 were counting the controlled narcotics, when Nurse #1 indicated she had given Resident #1, 2.25 mL verses the prescribed 0.25 mg of morphine. Nurse #1 indicated she had checked the physician order and when she got the medication out the label was blurry and the amount looked like a whole number, (Two) to her. Nurse #2 revealed they immediately checked on Resident #1. Her vital signs (VS) were within normal limits and she responded to her name when called. Nurse #2 revealed that the resident's VS were normal, and she was responding, she would continue to monitor the resident and notify the physician if there was any change. Nurse #2 indicated she notified the On-Call Medical Doctor that Resident #1 had received more liquid morphine than prescribed. In an interview on 9/18/23 at 12:38 PM the Director of Nursing (DON) revealed staff called her on 9/14/24 to notify her Resident #1 had received a medication error. Review of the Controlled Drug Record dated 9/14/24 at 10:00 PM documented Resident #1 received 2.25 mL of morphine on 9/14/24. On 9/19/23 the Director of Nursing completed a medication error report for Resident #1. The medication error report was completed for a resident who received 2.25 mL of morphine when the ordered dose was 0.25 mL. In an interview on 9/19/24 at 1:51PM the DON revealed the morphine bottle had measurements on the side of bottle, with a blue line to indicate the amount of liquid in Resident #1's 30 mL bottle. The DON revealed she filed a Medication Error report as Resident #1 received 2.25 mL of morphine when the order was for 0.25 mL. The DON stated Resident #1 did not receive 6.25 mL of morphine she was administered 2.25 mL. Observation of Resident #1's morphine bottle on 9/19/24 at 1:53 PM with the DON revealed 28.0 cc of morphine in the bottle.