STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345326	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrooke Court SC Ctr at Matthews Glen	740 Pavilion View Drive Matthews, NC 28105

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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. 50046 Based on observations, record review, staff, Nurse Practitioner (NP), and Pharmacist interviews the facility failed to maintain a medication error rate of less than 5% by having 3 errors out of 25 opportunities which resulted in an 12% medication error rate. This affected 1 of 3 residents observed for medication administration (Resident #57). Findings included: 1a. A Physician's order dated 5/21/24 read Ceftriaxone sodium (antibiotic) intravenous solution reconstituted 2 grams (gm), use 2 gm intravenously (IV) in the morning for sepsis until 6/27/24. A Physician's order dated 5/21/24 read Heparin (blood thinner) lock flush solution 10 units/ milliliter (ml), use 5 ml intravenously in the morning for after medication administration until 6/28/24, use SASH: saline flush, administer medication, saline flush, heparin flush. An observation and interview were made on 5/30/24 at 8:50 AM of Nurse #1 preparing Resident #57's medication. She removed a 10 milliliter (ml) normal saline (NS) flush and a heparin 5 units/ ml 5 ml flush from her medication cart. She then proceeded to take a bag of IV ceftriaxone (an IV antibiotic), IV tubing, the NS flush, and the heparin flush into Resident #57's room. Nurse #1 was observed to hang the bag of IV ceftriaxone sodium 2gm on the IV pole. She primed the IV tubing at Resident #57's bedside. Nurse #1 then cleaned the connection cap of the PICC line lumen with an alcohol swab. Nurse #1 opened the heparin flush from its packaging and connected the heparin flush to Resident #57's PICC line connection cap. Nurse #1 was stopped before she flushed Resident #57's PICC line with the heparin flush. Nurse #1 went back to her medication cart to review the flush orders for Resident #57's PICC line. After reviewing the PICC line flush orders on Resident #57's medication administration record (MAR), Nurse #1 said she was supposed to flush Resident #57's PICC line using the SASH (saline- administer medication-saline-heparin) method. She said she should have flushed the PICC line using a normal saline flush. Nurse #1 said she was nervous and got confused. (continued on next page)

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1b. Another observation was made on 5/30/24 at 9:45 AM of Nurse #1 disconnecting Resident #57's IV and flushing his PICC line. Nurse #1 was observed to take a NS 10 ml flush and a Heparin 5 unit/ml 5 ml flush from her medication cart and into Resident #57's room. She was observed to disconnect the IV tubing from Resident #57's PICC line. She cleaned the PICC line connection cap with an alcohol swab. She then held up an opened heparin flush to indicate which flush she intended to use first to flush Resident #57's PICC line, she did not connect the flush to the PICC line connection cap. Nurse #1 was stopped. She then proceeded to flush the PICC line with the 10 ml normal saline flush, followed by the 5 ml heparin flush. Nurse #1 said she was nervous and forgot which flush she was supposed to use first. An interview was conducted with the Director of nursing on 5/30/24 at 9:55 AM. She said Nurse #1 should have flushed Resident #57's PICC line using the SASH method. She said Nurse #1 had received training on IV administration, which included flushing of IV devices. She said she was not sure why Nurse #1 failed to flush Resident #57 PICC line correctly, except that she was nervous. An interview was conducted with the NP on 5/30/24 at 11:00 AM. She said there would probably be no adverse effect from using heparin to flush the PICC line before administering medication through the PICC line. She said Nurse #1 should have followed protocol and flushed the PICC line as ordered using the SASH method. An interview was conducted with the pharmacist on 5/30/24 at 11:19 AM. The Pharmacist said there was no adverse reaction between heparin and ceftriaxone. She said there would not be an adverse effect to the resident. The Pharmacist said that the heparin flush dose was not enough to be absorbed systemically and adversely affect the resident, even if the resident received other anticoagulant medications. An interview was conducted with the Administrator on 5/30/24 at 11:56 AM. The Administrator said she expected Nurse #1 to follow the protocol for flushing of PICC lines and that Nurse #1 should have followed the physician's orders. 2. A Physician's order dated 5/22/24 read Voltaren External Gel (topical analgesic) 1% (Diclofenac Sodium (Topical)) Apply to right shoulder topically three times a day for osteoarthritis, apply 2 grams (gm) to right shoulder three times daily. An observation was made on 5/30/24 at 8:58 AM of Nurse #1 preparing and administering Resident #57's medications. She was observed to squeeze a quarter sized amount of Voltaren 1% gel onto her gloved hand four separate times and applied the gel to Resident #57's left lower back, right lower back, left side, and right shoulder. An interview was conducted with Nurse #1 on 5/30/24 at 9:32 AM. She stated had never measured Voltaren gel for administration. Nurse #1 said she was not aware that Voltaren gel was supposed to be measured or that there was a dose card to measure the grams to be administered. She said she should have only applied the Voltaren gel to Resident #57 right shoulder as it was ordered. She said she applied the Voltaren gel to other areas because Resident #57 had requested it. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 5/30/24 at 9:55 AM. The DON said she had spoken to the pharmacy, and they confirmed Voltaren gel should be measured using a dosing card before being applied. She said she did not know why there was not a dose measuring card for Resident #57's Voltaren gel. She said the dose measuring card could have fallen out of the package or accidentally been thrown away. The DON stated that not measuring the Voltaren gel was a medication error. She said Nurse #1 should have only applied the Voltaren gel to Resident #57's right shoulder as specified in the order. She could not say why Nurse #1 applied the Voltaren gel to other areas. An interview was conducted with the NP on 5/30/24 at 11:00 AM. She said Nurse #1 should have measured the Voltaren gel before administering the medication. She said Nurse #1 should follow the physician's orders and should have only administered the Voltaren gel to Resident #57's right shoulder as specified in the order. An interview was conducted on 5/30/24 at 11:19 AM with the Pharmacist. She stated Voltaren gel should be measured using a dosage card before being applied. The Pharmacist stated that there was a maximum daily dose for Voltaren gel of 32 gm for the entire body. She stated if the maximum daily dosage was exceeded there could be adverse reactions. The Pharmacist explained Voltaren gel was a non-steroid anti-inflammatory (NSAID) medication. The Pharmacist said anytime an NSAID was used with an anticoagulant medication, there was always a labeled risk of an increased risk of bruising and bleeding. The Pharmacist stated with Voltaren gel being a topical medication the risk of it being absorbed systemically and causing an adverse effect was low. An interview conducted on 5/30/24 at 11:56 AM with the Administrator. She said the nurse should follow physician orders when administering medications. She said Nurse #1 should have measured the Voltaren gel before administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50934 Based on observations, record review, and staff and resident interviews the facility failed to store a medication and left it unattended at the bedside for 1 of 1 resident (Resident #5) reviewed for medication storage. The findings included: Resident #5 was admitted to facility on 5/9/24 with diagnosis that included constipation. A review of the Resident's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. A review of Resident #5's physician order dated 5/25/2024 revealed he was ordered Senna S Oral Tablet 8.6-50 milligrams (MG). The order continued to give 2 tablets by mouth one time a day for constipation and hold for loose stool. There was no self-administration assessment for any medication in Resident #5's medical record. Review of Resident #5's medical record revealed no care plan for self-administration of medications. On 5/29/24 at 9:29 AM an observation and interview was conducted with Resident #5 in his room. During the interview with Resident #5 was observed to knock over a napkin that contained an orange round pill off his bedside table. The pill was observed to fall to the floor. Resident #5 indicated the orange round pill was from the morning, and it was for his constipation. Resident #5 further indicated he liked to finish his breakfast prior to taking his medication for constipation. He stated that he took the rest of his morning medication but took his constipation pill later. An interview on 5/29/24 at 9:32 AM with Nurse #1 revealed Resident #5 wanted his stool softener after eating breakfast. Nurse #1 indicated she had left the Senna S Oral tablet on Resident #5's bedside table on purpose so he could take it after breakfast. Nurse #1 also indicated this was a consistent morning routine for Resident #5. An observation with Nurse #1 of Resident #5's Medication Administration Record (MAR) revealed it had been signed on 5/29/24 prior to Resident #5 taking the pill. On 5/29/24 at 2:34 PM the Nurse Supervisor indicated that a nurse should stand and observe a resident taking their medication before leaving the room. The Nursing Supervisor further indicated Nurse #1 should not have left Resident #5's medication at bedside. The MAR should not have been signed due to Resident #5 not consuming the Senna S Oral tablet. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 5/29/24 at 3:02 PM. The DON stated Resident #5 should have been observed taking his medication before Nurse #1 left the room. Medication should not be left for residents to take at their discretion. The DON further stated when a resident wanted to take a medication later than the time ordered, the nurse should not sign off on the MAR. The nurse should hold the pill and come back when the resident requests.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on observations, record review, staff, and Nurse Practitioner (NP) interview the facility failed to wear personal protective equipment (PPE) while administering medications through a peripherally inserted central catheter (PICC line) for a resident requiring Enhanced Barrier Precautions (EBP). This deficit practice occurred for 1 of 2 residents reviewed for EBP (Resident #57). Findings included: Review of the facility's policy and procedure revised on 3/2023, entitled Policy and procedures guidelines for isolation precautions read in part: Enhanced Barrier Precautions (EBP) are used as an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs). This precaution expands on the use of PPE and refers to the use of gown and gloves during high-contact resident care activities. That provides opportunities for transfer of MDROs to staff hands and clothing. EBP will be applied to resident with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status. Implementation- High-contact care activities that require gown and glove use for Enhanced Barrier Precautions include Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ ventilator. Resident #57 was admitted to the facility on [DATE]. Review of Resident #57 active physician orders for May 2024 revealed he had an order for EBP dated 5/21/24. He had an order dated 5/21/24 that read: Double Lumen PICC to left brachial vein inserted 5/20/24. An observation was completed on 5/28/24 at 12:41 PM and revealed Resident #57 had a double lumen PICC line in place to his left upper arm. There was an EBP sign on the outside of his door. There was a cart with PPE supplies including: gowns, mask, and gloves outside the door of his room. An observation was completed on 5/30/24 at 8:50 AM of Nurse #1 accessing Resident #57's PICC line prior to administering his intravenous (IV) medication. The nurse performed hand hygiene using hand sanitizer and donned clean gloves. She did not don a gown. Nurse #1 hung the IV medication on the IV pole and primed the IV tubing. She cleaned the PICC line lumen connection cap with an alcohol swab and connected a flush to the PICC line lumen. An interview was conducted with Nurse #1 on 5/30/24 at 8:58 AM. Nurse #1 stated she was aware that Resident #57 had EBP in place. She explained EPB should be used when providing direct care and changing wound dressings. Nurse #1 stated that if she was providing care for the PICC line or using the PICC line she should use EBP and wear a gown. She stated she had been nervous and forgot to put on the gown. An interview was performed with the Director of Nursing (DON) on 5/30/24 at 9:55 AM. The DON said Nurse #1 should follow EBP guidelines, which included wearing a gown when she accessed the PICC line to administer medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was performed with the Infection Preventionist (IP) on 5/30/24 at 10:50 AM. The IP stated that residents with indwelling medical devices such as PICC lines should have EBP in place. She said if a nurse was using the PICC line or changing the dressing then they should follow EBP, which included wearing a gown and gloves. An interview was performed with NP on 5/30/24 at 11:00 AM. The NP stated she was aware of EBP being used by the facility. She said Resident #57 had EBP in place for his PICC line and wounds. She stated Nurse #1 should have followed EBP when accessing Resident #57's PICC line. An interview was performed with the Administrator on 5/30/24 at 11:56 AM. She stated if residents have EBP in place, staff should follow the EBP guidelines when performing procedures. The Administrator said Nurse #1 should have followed EBP guidelines and worn a gown when accessing Resident #57's PICC line. She said Nurse #1 did not follow protocol.