

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Sanford Health & Rehabilitation CO		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 Farrell Road Sanford, NC 27330	

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)
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095</p> <p>Based on record review, Medical Director, Nurse Practitioner, staff and resident interviews the facility failed to prevent a significant medication error for 1 of 3 residents reviewed for medication administration when two blood pressure (BP) medications, Isosorbide mononitrate and hydralazine were not administered per orders for Resident #1. This resulted in Resident #1 's BP to drop to 82/50 causing a near syncope event that required a visit to the emergency room for further evaluation.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included, hypertension (HTN) (high blood pressure), acute cerebral vascular accident (CVA) (an interruption in the flow of blood to cells in the brain), coronary artery disease (CAD) with history of two myocardial infarctions (MI) (heart attack), and coronary artery occlusion.</p> <p>The most recent Minimum Data Set (MDS) coded as an admission assessment on 06/02/24 revealed Resident #1 was cognitively intact. No behaviors coded and no rejection of care were coded.</p> <p>Record review of active medications revealed an order dated 05/27/24 that read in part, hydralazine 50 milligram (mg) tablet: give 1 tablet; by mouth, three times a day. (Hold for systolic blood pressure (SBP) less than 120 related to essential (primary) hypertension. It also revealed an order dated 05/27/24 that read in part, isosorbide mononitrate 30 mg tablet extended release over 24 hours; give 1 tablet; by mouth once a day for BP greater than 160/90.</p> <p>The Medication Administration Record (MAR) for June 2024 revealed Resident #1 's BP reading to be 112/61 on 06/04/24 at approximately 9:00 AM. The MAR also revealed hydralazine 50 milligram (mg) tablet, hold for systolic blood pressure (SBP) less than 120 and isosorbide mononitrate 30 mg tablet extended release tablet, give once a day for BP greater than 160/90 was administered by Nurse #1.</p> <p>A phone interview was conducted with Resident #1 's responsible party on 06/12/24 at 9:52 AM. He stated when he arrived at the facility Resident #1 was in her wheelchair sitting outside in the courtyard. She was in the sun, not responding to him and she had sweat on forehead. He then stated he thought she had another stroke because when she opened her eyes and started talking to him her speech sounded slurred. He indicated this had happened before and that her BP goes up and down a lot. He further stated he yelled into the building for help and the nurse came to assist.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Nurse #1 on 06/12/24 at 1:23 PM. She verified she was Resident #1 ' s nurse on 06/04/24. She stated she checked Resident #1 ' s BP then administered hydralazine 50 mg 1 tablet and isosorbide mononitrate 30 mg tablet on 06/04/24. She indicated she did not thoroughly read the orders which included parameters for both medications. She further stated the hydralazine 50 mg tablet was to be held if her systolic blood pressure was below 120 and the isosorbide mononitrate 30 mg tablet was to be given for a BP greater than 160/90. She then indicated she was unaware of the parameters for the medications due to not thoroughly reading the orders.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/12/24 at 11:20 AM. The DON stated she was alerted by the voice of Resident #1 ' s responsible party that his mother appeared to be having another stroke. She then went to assist Nurse #1 with assessing Resident #1. She also stated Nurse #1 took her vital signs which were BP 82/50, temperature 97.1 axillary, and oxygen saturation was 98% on room air. She also had sweat on her forehead. Emergency Medical Services (EMS) were called for a possible stroke and while awaiting their arrival Resident #1 ' s BP went up to 104/66, she was alert and verbally responsive. Resident #1 ' s responsible party stated her BP fluctuates and sometimes bottoms out. She returned from the hospital with no issues noted. A review of Resident #1 ' s medication administration record (MAR) for 06/04/24 revealed a medication error related to BP medications being given outside of parameters to hold. She indicated that the medications should be given per order.</p> <p>Emergency Medical Services (EMS) records dated 06/04/24 revealed Resident #1 was assessed at the facility upon arrival at 10:52 AM. Call came in as possible stroke. Resident #1 ' s vital signs were as follows: blood pressure 128/69, pulse 77, respirations 14, temperature 98 degrees. Stroke screen with negative findings. Heart monitor applied and noted atrial fibrillation (A-Fib) present. Attempts to start intravenous saline lock times 2 were unsuccessful. Resident #1 was alert and oriented to event, person, place, and time. Skin diaphoretic, flushed, and hot.</p> <p>emergency room records revealed Resident #1 arrived on 06/04/24 at 11:30 AM with a damp gown on, awake, alert and oriented. She denied any pain and her responsible party stated she was close to her baseline. Her discharge diagnosis was near syncope (fainting or passing out), and no medications were given. Electrocardiogram (EKG) was performed which indicated A-Fib and a series of blood tests. No treatments, no intravenous fluids, or vital signs listed on emergency department records dated 06/04/24.</p> <p>An interview was conducted with the Administrator on 06/12/24 at 11:25 AM. She indicated that the medications should be given per order. She stated that an ad [NAME] (as needed) Quality Assurance Performance Improvement (QAPI) meeting was held on 06/04/24 to discuss the deficient practice, initiate the plan of correction and education for staff regarding following physician orders for medication administration.</p> <p>Review of the plans to monitor performance revealed the Staff Development Nurse or designee would review medication administration records to ensure physician parameters are followed for hypertension orders. This plan would not prevent another medication error from occurring.</p>		