DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

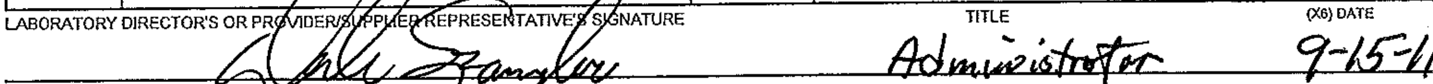
PRINTED: 09/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING ______ B. WING ______	C 08/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	The Center provided the following Plan of Correction (POC) without admitting or denying the validity or existence of the alleged deficiencies. The POC is prepared and executed solely because it is required by provisions of the Federal and State Law. The facility reserves all rights to contest findings through dispute, resolution, final appeal proceeding and any administrator or legal proceeding.	
	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			
	A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.		F 425	
	The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.		1. Resident #3 had medication substituted on 8/14/2011 by physician notification and visit. Order received for Albuteral Nebulizer 2.5mg "now". Medication was given at 2:45pm on 8/14/2011.	8/14/2011
	This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and staff interview, the facility failed to follow their policy in acquiring medications from the pharmacy on 1 (Resident #3)of 4 sampled residents. The finding includes:		2. Licensed Nurses will identify other residents of any medication shortage at the time of medication administration (med pass). All medication orders unavailable to the resident will be managed with urgency.	9/16/2011
	The facility's policy on providing pharmacy services dated 03/01/11 was reviewed. The policy stated that during normal business hours, the facility may contact the pharmacy by phone, fax, mail or hand delivery as specified and regulated by state regulations. After normal			

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



Administrator — 9-15-11

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.

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F 425	Continued From page 1 business hours, a registered pharmacist may be reached by dialing the provided telephone number. The policy also stated that if the pharmacy is already closed, the staff to call the on call pharmacist who in turns call the back up pharmacy. The policy also indicated that when orders received after normal business hours, to call the doctor if medication can be substituted using a medication that was available in the emergency drug supply. Resident #3 was admitted to the facility on 08/13/11 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Pleural Effusion, Diabetes Mellitus, Myocardial Infarction, Atrial Fibrillation, Congestive Heart Failure, Seizure Disorder, Hypertension, and left Elbow Fracture, status post surgery on 07/06/11. The admission doctor's orders were reviewed. Resident #3's medications included Brovana 7.5 mgs. (milligrams) via nebulizer twice a day (8 AM and 8 PM) and Pulmicort 0.5 mgs. via nebulizer twice a day (8 AM and 8 PM). Both medications were for COPD. Review of the Medications Administration Record for August, 2011 revealed that Resident #3 had not received both the Brovana and the Pulmicort at 8 PM (08/13/11) and 8 AM (08/14/11) doses. On 08/29/11 at 3:05 PM, Nurse #1 (admitting nurse) was interviewed. She stated that Resident #3 was admitted on 08/13/11 at 4:35 PM. She also stated that Nurse #2 (nurse in charge) was the one who transcribed the doctor's orders and faxed the orders to the pharmacy. Nurse #1 also	F 425	3. Facility will provide pharmaceutical services and assure the accurate acquiring, receiving, dispensing and administering of medications to meet the needs of each resident. During normal business hours the facility will contact the pharmacy by phone or fax. After hours, a pharmacist may be reached by phone. If the pharmacy is closed, the staff will call the on call pharmacist who in turn calls the back up pharmacy. If the medication is not available, the doctor will be notified for medication substitution available in emergency drug supply. Inservice given on 8/21/11 for License Nurses on Policy and Procedure 7.0 Pharmacy Services: Medication Shortages/Drugs not available. When medication orders are not received or available, the licensed nurse will immediately initiate action in cooperation with the attending physician and pharmacy provider.	8/21/2011

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F 425	Continued From page 2 indicated that she was the nurse assigned to Resident #3 on 08/14/11 (day shift). She acknowledged that Resident #3's medications including Brovana and Pulmicort did not arrive from the pharmacy. She also stated that she had administered some medications by borrowing from other residents but had not administered the Brovana and the Pulmicort. Nurse #1 indicated that she did not call the pharmacy to follow up the resident's medications. She indicated that now she knew that she had to call the on call pharmacist during off hours if needed. She also stated that she did not call the doctor to inform him that the medications were not available. On 08/29/11 at 3:29 PM, Nurse #2 was interviewed. She stated that she was the nurse in-charge that weekend and she was the one who transcribed the orders for Resident #3 and faxed them to the pharmacy. She stated that she faxed the orders around 6:42 PM. She indicated that she was not aware that the cut off time for the pharmacy to receive new orders was 2:00 PM on the weekend. She also stated that she was not aware that the resident's medications did not arrive on Saturday night delivery. She stated that now she knew that during off hours, if needed to call the on call pharmacist and the on call pharmacist will call the back up pharmacy. On 08/29/11 at 4:46 PM, the administrative staff was interviewed. She stated that the cut off time for the pharmacy to receive fax were 5:00 PM for the weekdays and 2:30 PM for the weekends. The administrative staff indicated that she expected the nurses to call the pharmacy twice if the medications were not delivered and if still not	F 425	4. Medication Administration Records will be monitored daily by nurse supervisor x2 weeks, then weekly x4, then on a quarterly basis. Findings will be reviewed in QI committee for continuous quality improvement to ensure that the deficient practice is being corrected and will not re-occur.	9/26/2011

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F 425	Continued From page 3 delivered to call the doctor. On 08/29/11 at 5:00 PM, Nurse #3 was interviewed via telephone. She stated that she was the 7P-7A shift nurse assigned to Resident #3 on 08/13/11. She stated that she did not administer the Brovana and the Pulmicort because they did not arrive from the pharmacy. She also stated that the pharmacy normally delivers the medications around 10:00 PM and at times at 4:00 AM as a second go round. She stated that if the medications did not arrive, she would inform the AM shift nurse to call the pharmacy. She also stated that she was not sure of the facility policy in acquiring medications from the pharmacy.	F 425		