STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING _____ B. WING _____	C 06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES NURSING & REHAB CENTER	523 COUNTRY CLUB DR FAYETTEVILLE, NC 28301

(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 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. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the pharmacy failed to supply the facility an ordered medication for 1 of 3 sampled residents (Resident #1). Findings included: The pharmacy policy dated July 2007 (no page number) titled, "Ordering and receiving medications from the dispensing pharmacy" read in part, "New medications, except for emergency or stat medications are ordered as follows: If	F 425	1. What was done for affected resident: Medication was delivered from pharmacy on morning of 5/24/12 to continue therapy. 2. What was done for rest of population: a. Facility licensed nursing staff was re-inserviced by Pharmacist Consultant on proper notification procedure when medications are needed prior to next scheduled pharmacy delivery. Education completed on or before 7/5/12. b. Pharmacy staff educated by staff Pharmacist/ Order Entry Supervisor on policy for obtaining medications prior to next scheduled pharmacy delivery. Education completed on 6/13/12. 3. What processes were changed: Pharmacy policy updated (see Attachment A-1&A-2) to emphasize pharmacy phone notification of orders that are needed prior to next scheduled delivery when order is written and faxed. Facility licensed staff in-serviced on updated pharmacy policy by Pharmacist Consultant with emphasis on calling pharmacy for orders that are needed prior to next pharmacy delivery. Education completed on or before 7/5/12. 4. Monitoring: Staff Pharmacist/Order Entry Supervisor to review call logs daily for called-in facility needs that could potentially require pharmacist involvement to decide the necessity of sending the medication through back-up or in next delivery. This will be an on-going process at a minimum of daily and as needed. Results of audits will be reported in pharmacy QA process and recorded in meeting minutes quarterly x 4 quarters. Variance or non-compliance with plan will be reviewed as to cause and changes made to the plan as needed and recorded in the QA meeting minutes. Appropriate staff at the pharmacy and/or the facility will be re-inserviced as needed. Monitoring of revised process will continue for additional quarters for effectiveness and discussed and documented in pharmacy quarterly QA meeting	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Rose LNHA	Administrator	7/3/12

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 needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery and request delivery within 4 hours." Resident #1 was readmitted into the facility on 5/15/12 and discharged on 6/1/12. Diagnoses included Seizures. The minimum data set completed on 5/22/12 indicated Resident #1's mental status was moderately impaired. A review of the nurses note dated 5/22/12 indicated Resident #1 was transported to the hospital via ambulance at 8:00 pm for signs/symptoms of a seizure. A review of the nurses note dated 5/23/12 indicated Resident #1 returned to the nursing facility at 2:50 am from the hospital with a physician order for Vimpat 100 milligrams (mg) twice daily. The nurses' note dated 5/23/12 at 5:30 pm indicated the pharmacy was contacted via fax by the 11 pm - 7 am nurse of the necessity of the ordered medication. The nurses' note dated 5/23/12 at 7:25 pm revealed the medication had not been delivered by pharmacy to the facility. A review of the physician telephone order dated 5/23/12 revealed a physician order for Vimpat 100 mg tab twice a day for seizures noted at 3:00 am. In a telephone interview on 6/13/12 at 11:00 am, Pharmacy Staff #1 (order entry staff) confirmed a medication script for Vimpat 100 mg was faxed to the pharmacy on 5/23/12.	F 425	5. The Director of Nursing or designee will audit the Medication Administration Records weekly times 4 weeks, then monthly times 3 months to ensure medications are received and given appropriately. Results of the audits will be discussed at the monthly Quality Assurance meetings. Additional in-service training, audits and changes in policy or procedures will be completed as needed.	

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F 425	Continued From page 2 In a telephone interview on 6/13/12 at 11:20 am, the Pharmacist confirmed that on 5/22/12 Vimpat 100 mg tablets were on hand at the pharmacy. The pharmacist concluded her expectation was that the medication should have been supplied to the facility to meet the need of the resident as ordered. In an interview on 6/13/12 at 11:35 am, the Director of Nursing stated she expected the pharmacy to supply medication as ordered to meet the needs of the residents.	F 425		