STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING ______ B. WING ______	C 05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(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 medical record review and interviews with staff, physician and a resident the facility failed to provide medications for 1 of 1 sampled residents. (Resident #3) The findings included: Resident #3 was admitted to the facility 05/17/15 after hospitalization 05/13/15-05/17/15 for symptoms related to ulcerative colitis. Hospital records indicated Resident #3 was restarted on Balsalazide (an anti-inflammatory medication) for	F 425	This plan of correction does not constitute an admission or agreement by provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and federal law. It is the practice of this facility to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals	6/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/12/2015

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
the ulcerative colitis and stabilized on the medication.

Admission physician orders on 05/17/15 included:
Balsalazide 750 milligrams (mg), 3 capsules three times a day (TID)
Methimazole 5 mg TID for hyperthyroidism

The admission Minimum Data Set dated 05/17/15 assessed Resident #3 as alert and oriented, with no memory problems and independent in decision making abilities.

On 05/20/15 at 9:40 AM and 4:50 PM Resident #3 reported not receiving the Balsalazide as ordered since admission; noting it was the only medication that kept her symptoms from ulcerative colitis under control. Resident #3 stated the day after admission (05/18/15) nursing staff told her the medication was not available to be given when she asked for the Balsalazide. Resident #3 stated she had been experiencing nausea, vomiting and diarrhea since 05/19/15 and attributed it to not taking the Balsalazide as ordered. Resident #3 stated she also did not receive the thyroid medication (Methimazole) on 05/18/15; noting nursing staff told her it was also not available to be given.

Review of the May 2015 Medication Administration Record (MAR) for Resident #3 on 05/20/15 noted the following:
Balsalazide 05/18/15 with three timed entries at 8:00 AM, 12:00 PM and 5:00 PM were initialed and circled with no explanation (where indicated) on the back of the MAR why the medication was not given
Methimazole 05/18/15 with three timed entries at 8:00 AM, 2:00 PM and 8:00 PM with only the 8:00

F 425
to meet the needs of each resident.

Resident #3 no longer resides at this facility.

All newly admitting residents have the potential to be affected by the alleged deficient practice.

The medication records for residents admitting between May 1, 2015 thru May 31, 2015, were reviewed by the Director of Clinical Services and Regional Director of Clinical Services to identify any discrepancies in documentation for acquiring, receiving, dispensing, and administering drugs and biologicals upon admission to meet the needs of each resident per the physician orders.

Licensed Nurses received education from the Director of Clinical Services on facility practice for medication administration beginning May 22, 2015 related to timely obtaining and dispensing of medications for newly admitted residents per physician orders. Newly hired licensed nurses will receive education upon hire. Licensed Nurses received education from the Omnicare Pharmacy Representative on May 27, 2015, on the procedure for timely procurement of physician ordered medications for newly admitted residents. Pharmacy education included procedures for ordering and obtaining medications on the weekends for newly admitted residents. Newly hired licensed nurses will receive education on weekend pharmacy processing upon hire.

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F 425	Continued From page 2 AM dose initialed as administered. On 05/20/15 at 3:00 PM Nurse #2 reported she worked on the unit Resident #3 resided on 05/18/15 from 3:00 PM-11:00 PM. Nurse #2 reported she did not administer the 5:00 PM dose of Balsalazide or 8:00 PM dose of Methimazole to Resident #3 on 05/18/15 because they were not available to be given. On 05/20/15 at 3:05 PM the Director of Nursing (DON) and corporate nurse stated they were not aware the Balsalazide and Methimazole were not available for administration to Resident #3 on 05/18/15. In a follow-up interview on 05/20/15 at 5:35 PM the DON and corporate nurse reported documentation showed the admission physician orders for Resident #3 were Fax'd to the dispensing pharmacy on 05/17/15 at 12:57 PM. The DON stated the medications were ordered prior to the resident's admission to the facility on 05/17/15 at 2:30 PM. The DON explained if possible, medications were ordered prior to the resident's arrival to ensure they were available to be administered. The DON noted the delivery ticket from the pharmacy indicated the medications were sent to the facility on 05/19/15 at 12:10 AM. The corporate nurse stated the dispensing pharmacy was closed on Sunday and 05/17/15 was a Sunday. The corporate nurse stated if medications were needed on a Sunday the dispensing pharmacy had to be notified by phone so arrangements could be made for delivery by a local pharmacy. The corporate nurse stated the dispensing pharmacy should have been called on 05/17/15 to request the medications and 05/18/15 when the medications were not available to be administered. The DON and corporate nurse verified the Balsalazide and	F 425	The admitting nurse will document on the Admission Physician Order Reconciliation Form that the physician has verified the admitting medication orders, and that the pharmacy has been contacted for timely procurement of medications. The Director of Clinical Services, Regional Director of Clinical Services, and/or Nursing Supervisor will validate at the time of admission that the admitting nurse has processed the physician orders to pharmacy services timely to procure the medications for the newly admitting resident in accordance with facility practice. Quality Improvement monitoring will be conducted by the Director of Clinical Services, Regional Director of Clinical Services, and/or Nursing Supervisor to validate that medications were received and administered upon admission to meet the needs of the resident per the physicians orders. Quality Improvement Monitoring will be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 time weekly for 12 weeks, and/or until substantial compliance is obtained. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the	

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THE OAKS AT SWEETEN CREEK	**3864 SWEETEN CREEK ROAD** **ARDEN, NC 28704**

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F 425	Continued From page 3	F 425		

Methimazole were not given to Resident #3 on 05/18/15 because the medications did not arrive at the facility until after midnight on 05/19/15.

On 05/21/15 at 8:55 AM Nurse #1 reported she worked on the unit Resident #3 resided on 05/18/15 from 7:00 AM-3:00 PM. Nurse #1 stated she did not administer the 8:00 AM and 12:00 PM doses of Balsalazide to Resident #3 on 05/18/15 because the medications were not available to be given. Nurse #1 stated the Methimazole was mistakenly initialed as given on 05/18/15 at 8:00 AM but it was not available and was not administered at 8:00 AM or 2:00 PM on 05/18/15. Nurse #1 stated she informed the resident's physician the Balsalazide and Methimazole were not available for Resident #3 on 05/18/15. In a follow-up interview on 05/21/15 at 11:40 AM Nurse #1 stated she was not aware to call the pharmacy if a medication was not available to be administered to a resident. Nurse #1 stated when medications were not available her practice had been to inform the residents physician of the unavailability of medication.

On 05/21/15 at 9:40 AM the physician of Resident #3 stated she was not aware the Balsalazide and Methimazole were not available for Resident #3 on 05/18/15 and didn't recall being informed the medication was not available on 05/18/15. The physician stated if the medications could have been available for administration to Resident #3 they should have been administered as ordered on 05/18/14. The physician stated she was not familiar with the Balsalazide to know if omission of the medication could have contributed to any negative side effects.

On 05/21/15 at 11:00 AM Nurse #3 stated she

monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Performance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and the Minimum Data Assessment Nurse.

Date of Completion: June 18, 2015

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F 425	Continued From page 4	F 425		

worked on 05/17/15 and recalled calling the dispensing pharmacy about the need for the admission medications for Resident #3. Nurse #3 stated she was aware the dispensing pharmacy had to be called for any medications needed on a Sunday and did not document the phone call made with the dispensing pharmacy. Nurse #3 stated usually it takes a couple hours for the medication to arrive from the pharmacy after they are called. Nurse #3 stated she worked until approximately 7:00 PM on 05/17/15 and did not see the medications for Resident #3 prior to leaving the facility. Nurse #3 stated she worked on 05/18/15 and was not informed of any concerns involving medications for Resident #3. Nurse #3 stated the medications for Resident #3 should have been available for administration to Resident #3 on 05/18/15 either from the dispensing pharmacy or the back-up local pharmacy.

On 05/21/15 at 11:15 AM the administrator stated the Balsalazide and Methimazole should have been available to be administered to Resident #3 on 05/18/15. The administrator stated action would be taken to prevent reoccurrence of the problem.

On 05/21/15 at 11:25 AM (via phone interview) the pharmacy manager from the dispensing pharmacy verified the Balsalazide and Methimazole were sent from the dispensing pharmacy on 05/18//15. The pharmacy manager stated medications could be delivered for residents on a Sunday but required a phone call from the facility. The pharmacy manager stated she would check the pharmacy phone logs to determine if a call was received on 05/17/15 about the need for the medications for Resident

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F 425	Continued From page 5 #3. The pharmacy manager never returned the call to report her findings.	F 425		