STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345050	A. BUILDING _____ B. WING _____	C 01/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

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F 000	INITIAL COMMENTS The survey team entered the facility on 1/6/21 to conduct a complaint investigation. The survey team was onsite 1/6/21 and 1/7/21. Additional information was obtained offsite on 1/8/21. Therefore, the exit date was 1/8/21. Event ID# MVKL11. One (1) of the 17 complaint allegations was substantiated with a citation identified at F755.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		1/30/21

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

Electronically Signed | 01/29/2021

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F 755	Continued From page 1 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff and pharmacy telephone interviews and record reviews, the facility failed to acquire a scheduled medication for administration, resulting in 7 doses of this medication being missed for 1 of 3 sampled residents (Resident #1) reviewed for the provision of pharmaceutical services to meet residents ' needs. The findings included: Resident #1 was admitted to the facility on 5/30/19. The resident was sent out to a hospital on 7/27/20 with re-entry to the facility on 7/31/20. His cumulative diagnoses included peripheral autonomic neuropathy (weakness, numbness or pain caused by nerve damage) and muscle spasms. The resident ' s physician orders dated 7/31/20 included a medication order for 200 milligrams (mg) pregabalin (a controlled substance medication which may be indicated for the treatment of neuropathic (nerve) pain to be given by mouth every 8 hours for pain. The medication was scheduled to be administered at 6:00 AM, 2:00 PM, and 10:00 PM each day. Pregabalin is a controlled substance medication. A review of Resident #1 ' s August 2020 electronic Medication Administration Record (MAR) and Controlled Substance Count Record	F 755	Jacob□'s Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob'□s Creek Nursing and Rehabilitation Center'□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob'□s Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 9-11-2020 resident #1 was discharged from facility. On 1-19-2021 the unit managers reviewed all residents with narcotics prescribed to them to ensure that pharmacy services were being provided to meet the need of each resident, to include the accurate	

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F 755	Continued From page 2 (a declining inventory log) was conducted. Documentation on these records revealed pregabalin was administered to the resident three times daily as ordered from 8/1/20 through 6:00 AM on 8/11/20. However, the documentation also indicated the following: --On 8/11/20 at 2:00 PM, the MAR and Controlled Substance Count Record showed no dose of pregabalin was administered. A chart code of "10" was documented on the MAR to indicate "Drug Not Available." --On 8/11/20 at 10:00 PM, documentation on the MAR indicated a dose of pregabalin was administered to the resident. However, the Controlled Substance Count Record indicated the last dose of pregabalin had been used for the resident at 6:00 AM on this date. --On 8/12/20 at 6:00 AM, the MAR and Controlled Substance Count Record showed no dose of pregabalin was administered. A chart code of "10" was documented on the MAR to indicate "Drug Not Available." --On 8/12/20 at 2:00 PM, the MAR and Controlled Substance Count Record showed no dose of pregabalin was administered. A chart code of "10" was documented on the MAR to indicate "Drug Not Available." --On 8/12/20 at 10:00 PM, the MAR and Controlled Substance Count Record showed no dose of pregabalin was administered. A chart code of "10" was documented on the MAR to indicate "Drug Not Available." --On 8/13/20 at 6:00 AM, the MAR and Controlled Substance Count Record showed no dose of pregabalin was administered. A chart code of "10" was documented on the MAR to indicate "Drug Not Available." --On 8/13/20 at 2:00 PM, the MAR and Controlled Substance Count Record showed no dose of	F 755	acquiring of scheduled narcotics for administration. There were no negative findings. On 1-25-2021 the staff facilitator and unit managers initiated re-education to all nurses and medication aides on providing pharmacy services to meet the need of each resident, to include the accurate acquiring of scheduled narcotics for administration. All nurses and medication aides, including agency staffing, will be re-educated by 1-30-2021. This education will be part of the orientation process for all newly hired nurses and medication aides, including agency staffing. The facility interdisciplinary team members will review all new admissions and new physician orders for scheduled narcotic orders in clinical meeting daily. The unit managers will audit each unit's medication cart, utilizing the Narcotic Audit tool, weekly for 90 days, to determine if pharmacy services are being provided to meet the need of each resident, to include the accurate acquiring of scheduled narcotics for administration. The Compliance Monitoring tool will be utilized. Immediate action and/or re-education will be completed if any areas are identified. To maintain, the results of the follow up items and compliance will be submitted to the facility's Quality Assurance meeting monthly for 3 months and as needed.	

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F 755	Continued From page 3	F 755		

pregabalin was administered. A chart code of "10" was documented on the MAR to indicate "Drug Not Available."

Resident #1 ' s August 2020 electronic MAR and Controlled Substance Count Record documented pregabalin was administered to the resident on 8/13/20 at 8:00 PM upon receipt of the medication from the facility ' s contracted pharmacy.

A telephone interview was conducted on 1/6/21 at 4:15 PM with a dispensing pharmacist from the facility ' s contracted pharmacy. During the interview, the pharmacist reported the pharmacy dispensed 200 mg pregabalin capsules for Resident #1 on the following dates, in part:
--On 7/7/20, 90 capsules of 200 mg pregabalin were dispensed with directions to give 1 capsule by mouth three times a day.
--The next fill of pregabalin was dispensed on 8/13/20 with 90 capsules of 200 mg pregabalin sent to the facility for Resident #1 with directions to give 1 capsule by mouth every 8 hours. The pharmacist reported the pregabalin would have been received by the facility the evening of 8/13/20.

An interview was conducted on 1/7/21 at 2:25 PM with the facility ' s Administrator. During the interview, concern regarding Resident #1 missing 7 doses of pregabalin between 6:00 AM on 8/11/20 and 8:00 PM on 8/13/20 was discussed. When asked, the Administrator reported she would have expected nursing staff to pull the refill reminder sticker from the med card containing the pregabalin and to reorder it from the pharmacy. She noted this would need to be done a few days before running out of the pregabalin (a

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F 755	Continued From page 4	F 755		

controlled substance) so no doses of the medication would be missed.

A telephone interview was conducted on 1/8/21 at 10:53 AM with Nurse #1. Nurse #1 was identified by her initials on Resident #1 ' s MAR as being assigned to pass medications to the resident on both 8/11/20 at 2:00 PM and 8/13/20 at 2:00 PM. Nurse #1 had documented Resident #1 ' s pregabalin was not available for administration on each of these dates/times. During the interview, the nurse stated she vaguely recalled coming in to work at a time when the resident ' s pregabalin was not available for administration as scheduled. She reported the resident did report having pain, so his physician was contacted and an order was received to provide an alternative medication. However, the nurse stated the alternative medication didn ' t help much and the resident was pretty upset his usual medication was not available.

Unsuccessful attempts were made to contact Nurse #2, Nurse #3 and Nurse #4 by telephone. Nurse #2 was an Agency (temporary) nurse who was identified by her initials on Resident #1 ' s MAR as being assigned to pass medications to the resident on 8/11/20 at 10:00 PM. Nurse #3 was also an Agency nurse who was identified by her initials on Resident #1 ' s MAR. Nurse #3 was assigned to pass medications to the resident on 8/12/20 at 6:00 AM and on 8/13/20 at 6:00 AM when she documented the pregabalin was not available. Nurse #4 was no longer employed by the facility. Nurse #4 was assigned to pass medications to the resident on 8/12/20 at 2:00 PM when she documented the medication was not available for administration.

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A telephone interview was conducted on 1/8/21 at 11:44 AM with Nurse #5. Nurse #5 was identified by her initials on Resident #1 ' s MAR as being assigned to pass medications to Resident #1 on 8/12/20 at 10:00 PM. The nurse documented on this date/time the resident ' s pregabalin was not available for administration. During the interview, Nurse #5 reported she found out Resident #1 ' s pregabalin was out when it came time to give it to him. She stated, "He cussed me out," but then apologized to her for doing so. When asked if the resident was in pain, she reported he said he was not hurting bad. When asked what she did at that time, Nurse #5 reported offering him acetaminophen (an over-the-counter pain medication) but he didn ' t want to take it. The nurse stated she looked in the electronic medical record to be sure the medication was on order and found out it was. Upon further inquiry, Nurse #5 stated she always writes on her 24-hour nursing report if a resident has less than 10 tablets or capsules of a medication left. These notes were given to the Nurse Supervisors to serve as an alert in case a prescription needed to be obtained from the resident ' s physician or Nurse Practitioner before the med could be dispensed by the pharmacy.

A follow-up telephone interview was conducted on 1/8/21 at 1:45 PM with the facility ' s Administrator. During the interview, the Administrator reported she investigated the concern regarding Resident #1 ' s medication (pregabalin) not being available for 2-3 days in August 2020. She stated her investigation revealed the facility was not able to obtain a signed prescription from the prescriber until after 5:00 PM on 8/12/20. Since the prescription was obtained after 5:00 PM, the medication was not

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F 755	Continued From page 6 sent out by the pharmacy until the next day. Medication records confirmed the pregabalin for Resident #1 was received by the facility on 8/13/20.	F 755		