STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 03/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	333 HAWTHORNE LANE CHARLOTTE, NC 28204

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and record review, the facility failed to administer an intravenous (IV) antibiotic per physician orders for one (1) of one (1) sampled resident with readmission IV antibiotic orders (Resident #1). The findings are: Resident #1 was readmitted to the facility on 2/25/11 following a hospitalization for pneumonia. Review of the hospital discharge summary dated 2/25/11 revealed Resident #1 was treated with Meropenum (an antibiotic) intravenously every 8 hours. Review of the physician's readmission orders dated 2/25/11 included Meropenum 1,000mg IV every 8 hours through March 3, 2011. The hospital discharge summary dated 2/25/11 documented Resident #1 received this antibiotic for treatment of pneumonia and was on his fifth day of a fourteen day treatment. There was no documentation of the last dose administered prior to readmission to the facility. Review of Resident #1's February 2011	F 309	Filing the plan of correction does not constitute admission that the alleged deficiencies did in fact exist. The plan of correction is filed in evidence of the facilities desires to comply with the code of federal regulations and to continue to provide high quality care. F 309 Corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice by: Resident #1 had an order to administer ABT on arrival and resident received first does on 2/26/11 at 7:00 pm. All doses of the medication were completed on 3/3/11. Physician stated that there were no negative outcomes from receiving the medication when given. RECEIVED MAY 05 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ✓ | TITLE ✓ ADMINISTRATOR | (X6) DATE ✓ 4/14/11

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 309	Continued From page 1 Medication Administration Record revealed there was no documentation of Meropenem administration on 2/25/11 and for the scheduled 8:00 AM and 4:00 PM doses on 2/26/11. There was documentation of administration of the first dose of Meropenum at 12:00 AM on 2/27/11. Review of Resident #1's nursing notes dated 2/25/11 revealed Resident #1 was readmitted to the facility at 6:00 PM. Review of nursing notes dated 2/26/11 at 8:30 PM revealed the facility contacted the pharmacy three times and was informed the IV medication would be delivered at 3:00PM that day (2/26/11). When the medication failed to arrive, the facility contacted the pharmacy and was informed the delivery would occur in the evening. The pharmacy did not deliver the medication until 7:00 PM. According to nursing notes, the resident received the first dose of antibiotic after returning to the facility at 6:00 PM on 2/25/11. The medication arrived at 7:00 PM on 2/26/11 and was administered immediately by Licensed Nurse #1. Review of the nursing note dated 2/26/11 revealed Resident #1's physician received notification of the delay in administration. There was no documentation of the time of notification. Review of a verbal physician's order dated 2/26/11 revealed direction to administer medication when available. There was no documentation of time of the verbal order. Interview with the Director of Nursing (DON) at 10:50 AM on 3/29/11 revealed Resident #1's readmission from the hospital occurred after the facility's pharmacy regular business hours. The DON explained admission medications were	F 309	Corrective Action will be accomplished for those residents having potential to be affected by the alleged deficient practice by: All new admitted residents will have orders verified by MD, signed by the charge nurse, faxed to pharmacy (time noted of fax and call pharmacist to verify receipt of orders). Any medications not received, the charge nurse will call the on call pharmacist to have the backup pharmacy deliver. What measures will be put into place to ensure that the alleged deficient practice will not occur: All new admitted residents will have orders verified by MD, signed by the charge nurse, faxed to pharmacy (time noted of fax and call pharmacist to verify receipt of orders). Any medications not received, the charge nurse will call the on call pharmacist to have the backup pharmacy deliver. All nurses will be educated on pharmacy medication ordering process for new admissions, routine orders, and medications not received on routine delivery, and after hours process for contacting the pharmacy on call.	

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F 309	Continued From page 2 ordered after a resident was physically on-site. The DON reported she expected the back-up pharmacy to be used for medication orders after regular business hours. She did not know the cause for delay in delivery. The DON confirmed that on 2/25/11 and 2/26/11 Resident #1 did not receive a total of three doses of Meropenum, 1,000mg as ordered by his physician. Telephone interview with Resident #1's physician at 1:00 PM on 3/29/11 confirmed she received notification of the interruption of IV antibiotic administration on 2/26/11.	F 309	Facility will monitor its performance to ensure that the corrective action is achieved and sustained and evaluated for effectiveness. All new admissions will have a 24 hour documented chart review by the DON or supervisor. All telephone orders will be reviewed each morning (Monday-Friday, Saturday-Sunday) by the DON or Supervisor to ensure orders were checked and medication are in the building for 3 months. The audit results will be reviewed at the monthly Quality Assurance Meeting. Corrective Action Completed on 4/22/11.	
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	F 425	F425 Corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice by: Resident #1 had an order to administer ABT on arrival and resident received first does on 2/26/11 at 7:00 pm. All doses of the medication were completed on 3/3/11.	

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F 425	Continued From page 3 by: Based on interviews, record review and facility record review, the facility failed to acquire intravenous (IV) antibiotic medication per physician orders for one (1) of one (1) sampled resident with readmission IV antibiotic orders (Resident #1). The findings are: Review of the facility's Medication Ordering and Receiving policy and procedure dated 3/1/11 revealed "if new medications are needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of need for prompt delivery and request medication be called in to the back up pharmacy." The procedure directed the facility to contact the on-call pharmacy representative when medications were not available in the emergency drug supply. Resident #1 was readmitted to the facility on 2/25/11 following a hospitalization for pneumonia. Review of the hospital discharge summary dated 2/25/11 revealed Resident #1 was treated with Meropenum (an antibiotic) intravenously every 8 hours. Readmission medication orders included Meropenum 1,000mg IV every 8 hours through March 3, 2011. Review of Resident #1's February 2011 Medication Administration Record (MAR) revealed the antibiotic should have been administered starting on 12/26/11 at 12:00 AM and given every eight hours at 8:00 AM, 4:00 PM and 12:00 AM. According to the MAR the antibiotic was not given until 12:00 AM on 2/27/11	F 425	Corrective Action will be accomplished for those residents having potential to be affected by the alleged deficient practice by: Pharmacy in-serviced all nurses on medication ordering process for all new admissions, procedures for after hours and emergencies and the delivery process. Pharmacy provided "Quick Reference Cards" at nurses station for after hours process for obtaining meds. Pharmacy to add a Clinical Support Tech to provide monthly or as needed pharmacy support . What measures will be put into place to ensure that the alleged deficient practice will not occur: Pharmacy in-serviced all nurses on medication ordering process for all new admissions, procedures for after hours and emergencies and the delivery process . Pharmacy provided "Quick Reference Cards" at nurses station for after hours process for obtaining meds. Pharmacy to added a Clinical Support Tech to provide monthly or as needed pharmacy support.	

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F 425	Continued From page 4 Review of Resident #1's nursing notes dated 2/25/11 revealed Resident #1 was readmitted to the facility at 6:00 PM. Review of nursing notes dated 2/26/11 revealed the facility contacted the pharmacy three times and was informed the IV medication would be delivered on 2/26/11 at 3:00PM. When the medication failed to arrive, the facility contacted the pharmacy and was informed the delivery would occur in the evening. According to the nursing notes, the pharmacy delivered the medication on 2/26/11 at 7:00 PM and LN #1 administered the medication. Interview with the Director of Nursing (DON) at 10:50 AM on 3/29/11 revealed Resident #1's readmission from the hospital occurred after the facility's pharmacy regular business hours. The DON reported she expected the back-up pharmacy to be used for medication orders after regular business hours. The DON revealed IV medications were not part of the emergency drug supply. She did not know the cause for delay in delivery of the Meropenum. Telephone interview with the facility's pharmacy representative at 12:55 PM on 3/29/11 revealed IV medications did not come from the back up pharmacy. She explained all IV medications were dispensed from the main pharmacy and delivered as soon as possible. The pharmacy representative explained the facility's back up pharmacy provides oral but not IV antibiotics. Telephone interview with Resident #1's physician at 1:00 PM on 3/29/11 confirmed she received notification of the interruption of IV antibiotic administration on 2/26/11. Telephone interview with Licensed Nurse (LN) #1	F 425	Facility will monitor its performance to ensure that the corrective action is achieved and sustained and evaluated for effectiveness. DON or Supervisor to review the pharmacy delivery sheets to verify on time delivery of all resident medications. Pharmacy Consultant to review and report on Back Up Pharmacy Log at QA Meeting. This form is used to document any orders called into back-up pharmacies and after hours. It is completed whether Medipack or the Back Up Pharmacy dispenses the medication. Corrective Action Completed on 4/22/11.	

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F 425	Continued From page 5 at 2:00 PM on 3/29/11 revealed she called the on call pharmacy representative shortly after arriving on duty at 7:00 AM on 2/26/11 and requested delivery of the medication. Telephone interview with LN #2 at 2:05 PM on 3/29/11 revealed she ordered Resident #1's medication after midnight on 2/26/11. LN #2 reported she faxed the medication orders to the facility's pharmacy. A second interview with the DON at 2:10 PM on 3/29/11 revealed she was not aware the back up pharmacy did not provide IV medications for pick up or delivery. She revealed the IV antibiotic medication should be available for administration as soon as possible for the next scheduled dose.	F 425		