April 8, 2013 accept

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345002	A. BUILDING _____ B. WING _____	C 03/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-CYPRESS POINTE	2006 S 16TH ST WILMINGTON, NC 28401

(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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to prevent Resident #1 from receiving the wrong intravenous antibiotics medication that was prescribed to Resident #2. This was evident in two of three residents reviewed for unnecessary medications. Findings included:	F 329	It is the policy and practice of the facility to practice the "5 Rights" and correctly administer all medications according to physician orders. Resident Specific: Resident #1 was administered the wrong I.V. antibiotic on 2/28/2013 by the licensed nurse. Upon discovery of this incident immediate action was taken. The resident was assessed by the Licensed Nurse, vital signs were taken, resident was alert and oriented, there was no change in her baseline condition. Director of Nursing did an immediate review of medication allergies, the resident did not have sensitivity to drugs in the penicillin family as that was the I.V. drug that was incorrectly given. The Assistant Director of Nursing notified the physician of the error; the Physician gave orders for vitals signs each shift, monitor for any change in condition or signs and symptoms of adverse reaction. The Staff Pharmacist was notified of the I.V. medication error, he inquired if allergies had been checked, stated that he would document the error and to notify the Physician for further orders. The Family discovered the I.V. medication error; the DNS, ADNS, and Executive Director spoke with the family immediately upon discovery of the I.V. medication error and told them that an investigation was beginning immediately.	

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

Karla Whitley, RN, MSN, Executive Director 4/15/2013 (Submitted 5 Signature 4/8/2013). AHO

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.

X

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KINDRED TRANSITIONAL CARE & REHAB-CYPRESS POINTE	2008 S 16TH ST WILMINGTON, NC 28401

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F 329	Continued From page 1 1. Resident #1 was admitted to the facility from the hospital on 02/27/13 with cumulative diagnoses of colonic neoplasm requiring hemicolectomy and cellulites of the incision site. Record review of the physician orders sheet written on 02/27/13 during the admission process, revealed an order for Piperacillin/Tazobactam (Zyvox) 3.375 grams via IV (intravenous) route every 6 hours for seven days. Record review of the Medication Variance Report written on 02/28/13, revealed Resident #1 received Penicillin GK 3 million units IV (intravenously) instead of Piperacillin. A photocopy of the IV bag and labeling was attached to the Variance Report. The IV bag label contained the name of the drug (Penicillin GK), the dose (3 million units), the expiration date (02/11/13) and the name of another resident of the facility. In an interview with the Administrator and Assistant Director of Nursing (ADON) on 03/06/13 at 10:30 AM, they revealed that they were aware that Resident #1 had received the wrong antibiotic on 02/28/13 at 7 AM. The Administrator stated that she and the Director of Nursing (DON) and ADON were in a meeting around 10 AM on 02/28/13 when the house supervisor came to get them. The house supervisor told them that Resident #1 had a visit from a family member. The family member looked at the IV bag hanging on the pole and noted that it had another resident's name on the bag. The ADON stated that she and the DON went to Resident #1's room immediately to start an investigation. The family member had	F 329	Administrator and Director of Nursing were informed at approximately 10am of the I.V. medication error; the licensed nurse who was responsible for the error was removed from the floor immediately, pending investigation and later terminated. The resident's vital signs were taken as per physician orders; no adverse reaction was noted. Resident #2 had an I.V. antibiotic ordered by the physician. Several doses were left in the refrigerator and not signed off as given on the IM antibiotic, which was ordered to be given weekly times three weeks, it was not received from the pharmacy and was thereby entirely omitted; the staff pharmacist stated that they never received the order for Penicillin I.M. Upon discovery, the physician was immediately notified and provided the instruction to draw a lab sample with the value called to him to assist him in determining whether or not to reorder the omitted medication. Based on the lab value, the medication was deemed unnecessary and was not reordered. <u>Corrective Action for all Potentially Effected</u> On 2/28/2013 t he Assistant Director of Nursing immediately completed a 100% audit of all IV Medications ordered and being administered in the facility. Each I.V. medication was validated against the original order, the MAR, and the I.V. medication being administered. No other errors were noted. All IV antibiotics infusing were found to be per MD order. On 3/6/2013 the Data Entry LPN and the Medical Records Coordinator completed a 100% audit of allergy stickers on charts to assure the correct information was documented on the charts and MAR's.	

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F 329	Continued From page 2 removed the empty IV bag from the pole and would not surrender it to facility staff but did allow the facility to copy the labeling in her presence. The DON and ADON reviewed the clinical chart orders and against the IV bag labeling and it was determined that an error had occurred. The attending physician was notified by the ADON and he ordered the resident to have vital signs checked every shift. The physician told the ADON he did not expect Resident #1 to have any adverse complications since she was not allergic to penicillin, and that piperacillin was in the penicillin family of medications. The nurse who had administered the wrong medication was removed from the floor and interviewed by the Director of Nursing who documented the questions and answers on a facility investigation form, dated 02/28/13 and signed by the nurse who had administered the wrong medication. The investigation form revealed that Nurse #1 was assigned to Resident #1 on 02/28/13 and she started the IV antibiotic at approximately 6 AM. The investigation form revealed that when nurse #1 was asked if she looked at the resident's name, expiration date, medication dose and route prior to administration, nurse #1 answered "I looked at the bag and saw cillin on it." The investigation form documented "Q (question to nurse #1): You did not check the bag once you went into (resident#1's) room?" The answer from nurse #1 was "I know I looked down at the bag but I don't remember checking the name (Resident)." "Q (question to nurse #1): Did you check for allergies?" The answer from nurse #1 was "Yes I checked for allergies when I was passing her medications." In an interview with the Administrator on 03/06/13	F 329	On 03/06/2013 the Data Entry LPN reviewed all I.V., I.M., and P.O. orders for antibiotics within the past 45 days; the orders were compared against the pharmacy records to assure that no orders had been missed. All MARs that included antibiotic orders were reviewed to assure medications were being given as ordered. The Assistant Director of Nursing inspected each medication room and refrigerator for expired, outdated or discontinued medications or those of residents who had been discharged to assure that only those medications appropriate for current use remained in the facility. The Pharmacy Consultant completed his monthly review of all charts to assure there were no additional errors or omissions. There were no additional errors found. Systemic Corrections: The Staff Development Coordinator completed re-training of all licensed staff on all shifts on the "Five Rights of Medication Administration". This training began on 02/28/2013 and was completed 03/09/2013. On 03/13/2013 the Pharmacy Consultant completed an in-service for licensed nurses on "Medication Administration 101" and specifically discussed the risks of medication error and/or omissions.	

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F 329	Continued From page 3 at 1 PM, she stated that nurse #1 had removed an IV fluid bag from the medication refrigerator and set the bag on the counter. Another bag of IV fluids was on the counter. Nurse #1 told the administrator that she stopped to talk to another staff member. When the conversation was finished, she picked up the wrong bag and saw "cillin" on the bag, went to Resident #1's room, hung the bag, and she never checked the resident's name against the bag of IV antibiotic. Review of the report to the Board of Nursing dated 02/28/13 revealed: "On 02/28/13, at approximately 8:00 (AM) Nurse (#1) obtained IV fluid bag with antibiotic from refrigerator in medication room and set it out on the counter. She was then interrupted by a co-worker asking her a question. She picked up the bag noting that she could see the letters "cillin" and took it to the room. She hung the bag, attached it to the patient and started the IV and flushed the peripheral site. Shortly after, the family arrived, looked at the bag noting that it did not have the correct resident's name on it, and (the family) immediately alerted the Director of Nursing. Upon observation the DON noted that it was the wrong patient name on the bag (Resident #2 not Resident #1), was Penicillin not [sic] Piparacillen and was expired. Additional Comments: IV medication administered was expired, wrong patient, wrong drug. However it [the medication that was hung] should have been removed from the refrigerator prior to the incident." The nurse was suspended pending investigation and terminated. A medication variance report was done and the incident was faxed to the N.C. Board of Nursing.	F 329	The Director of Nursing initiated a new form for the night shift licensed nurses to perform weekly checks in the medication rooms to assure only medications appropriate for current use are in the facility. In addition, the Director of Nursing or designee will audit each medication storage area on a weekly basis x 3 months and then bi-weekly ongoing; to assure this corrective action is sustained. 100% of new written or telephone physician's orders are now reviewed in clinical rounds by a member of the clinical team on the next business day to assure all orders are completed; medications are matched against the MAR to assure correct transcription. Beginning 03/06/2013- Prior to any IV medication being administered, two nurses must now review the order, the medication, and sign off indicating a full review of the Five Rights: Right patient, right medication, right dose, right time, and right route in the resident's room. Sustained Compliance: Staff Development Coordinator will complete random medication administration observation with all licensed nurses and medication aides monthly x 3 months then re-evaluate. Each observation will include at minimum of 10 opportunities. These observations will be provided to the Director of Nursing for review in Performance Improvement for 3 months. The Staff Development Coordinator will re-educate the licensed nurses and medication aides; the re-education will be reflective of the outcome of the medication observations.	

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F 329	Continued From page 4 The family removed the resident from the facility that afternoon and moved her to another skilled nursing facility in the area During the interview on 03/06/13 at 10:30 AM, the Administrator shared the copy of the IV bag label. The label had Resident #2's name. The label had the medication as "Penicillin GK (Pfizerpen), dose 3 mu (million units), Administer 106 ml over 30 minutes every 4 hours Intravenously." The label indicated the medication was dispensed from the pharmacy on 02/04/13 and that the medication expired on 02/11/13. When the Administrator was asked "why was this medication in the refrigerator?" she stated that it should have been sent back to the pharmacy when the treatment ended on 02/08/13. Record review of Resident #2's Medication Administration Record revealed several doses of Penicillin GK were not signed off as given by the nurses during the month of January, 2013. The Penicillin GK order was discontinued on 02/08/13 after the midnight dose. The doses that were not given were left in the refrigerator and inadvertently were given to Resident #1.	F 329	All corrective action will be tracked and trended with changes in procedure made as appropriate. The results of this tracking will be presented to the Process/Performance Improvement Committee and the Medical Director on a monthly basis for review in response to any negative outcomes. Date of Compliance Immediate corrective action was initiated on 02/28/2013. All corrective actions related to TAG 329 were completed by 3/22/2013.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to prevent two significant	F 333	It is the policy and practice of the facility to practice the "5 Rights" and correctly administer all medications according to physician orders. Resident Specific: Resident #1 was administered the wrong I.V. antibiotic on 2/28/2013 by the licensed nurse. Upon discovery of this incident immediate action was taken. The resident was assessed by the Licensed Nurse, vital signs were taken, resident was alert and oriented, there was no change in her baseline condition.	

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F 333	Continued From page 5 medication errors by administering the wrong intravenous antibiotic medication to one resident (Resident #1) and failing to administer three intramuscular injections of antibiotic to a resident (Resident #2) for two of three residents reviewed for medication error. Findings included: 1. Resident #1 was admitted to the facility from the hospital on 02/27/13 with cumulative diagnoses of colonic neoplasm requiring hemicolectomy and cellulites of the incision site. Record review of the physician orders sheet written on 02/27/13 during the admission process, revealed an order for Piperacillin/Tazobactam (Zyvox) 3.375 grams via IV (intravenous) route every 6 hours for seven days. Record review of the Medication Variance Report written on 02/28/13, revealed Resident #1 received Penicillin GK 3 million units IV (intravenously) instead of Piperacillin. A photocopy of the IV bag and labeling was attached to the Variance Report. The IV bag label contained the name of the drug (Penicillin GK), the dose (3 million units), the expiration date (02/11/13) and the name of another resident of the facility. In an interview with the Administrator and Assistant Director of Nursing (ADON) on 03/06/13 at 10:30 AM, they revealed that they were aware that Resident #1 had received the wrong antibiotic on 02/28/13 at 7 AM. The Administrator stated that she and the Director of Nursing (DON) and ADON were in a meeting around 10 AM on 02/28/13 when the house supervisor came to get them. The house	F 333	Director of Nursing did an immediate review of medication allergies, the resident did not have sensitivity to drugs in the penicillin family as that was the I.V. drug that was incorrectly given. The Assistant Director of Nursing notified the physician of the error; the Physician gave orders for vitals signs each shift, monitor for any change in condition or signs and symptoms of adverse reaction. The Staff Pharmacist was notified of the I.V. medication error, he inquired if allergies had been checked, stated that he would document the error and to notify the Physician for further orders. The Family discovered the I.V. medication error; the DNS, ADNS, and Executive Director spoke with the family immediately upon discovery of the I.V. medication error and told them that an investigation was beginning immediately. Administrator and Director of Nursing were informed at approximately 10am of the I.V. medication error; the licensed nurse who was responsible for the error was removed from the floor immediately, pending investigation and later terminated. The resident's vital signs were taken as per physician orders; no adverse reaction was noted. Resident #2 had an I.V. antibiotic ordered by the physician. Several doses were left in the refrigerator and not signed off as given on the IM antibiotic, which was ordered to be given weekly times three weeks, it was not received from the pharmacy and was thereby entirely omitted; the staff pharmacist stated that they never received the order for Penicillin I.M. Upon discovery, the physician was immediately notified and provided the instruction to draw a lab sample with the	

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F 333	Continued From page 6 supervisor told them that Resident #1 had a visit from a family member. The family member looked at the IV bag hanging on the pole and noted that it had another resident's name on the bag. The ADON stated that she and the DON went to Resident #1's room immediately to start an investigation. The family member had removed the empty IV bag from the pole and would not surrender it to facility staff but did allow the facility to copy the labeling in her presence. The DON and ADON reviewed the clinical chart orders and against the IV bag labeling and it was determined that an error had occurred. The attending physician was notified by the ADON and he ordered the resident to have vital signs checked every shift. The physician told the ADON he did not expect Resident #1 to have any adverse complications since she was not allergic to penicillin, and that piperacillin was in the penicillin family of medications. The nurse who had administered the wrong medication was removed from the floor and interviewed by the Director of Nursing who documented the questions and answers on a facility investigation form, dated 02/28/13 and signed by the nurse who had administered the wrong medication. The investigation form revealed that Nurse #1 was assigned to Resident #1 on 02/28/13 and she started the IV antibiotic at approximately 6 AM. The investigation form revealed that when nurse #1 was asked if she looked at the resident's name, expiration date, medication dose and route prior to administration, nurse #1 answered "I looked at the bag and saw cillin on it." The investigation form documented "Q (question to nurse #1): You did not check the bag once you went into (resident#1's) room?" The answer from nurse #1 was "I know I looked down at the bag	F 333	value called to him to assist him in determining whether or not to reorder the omitted medication. Based on the lab value, the medication was deemed unnecessary and was not reordered. Corrective Action for all Potentially Effected On 2/28/2013 t he Assistant Director of Nursing immediately completed a 100% audit of all IV Medications ordered and being administered in the facility. Each I.V. medication was validated against the original order, the MAR, and the I.V. medication being administered. No other errors were noted. All IV antibiotics infusing were found to be per MD order. On 3/6/2013 the Data Entry LPN and the Medical Records Coordinator completed a 100% audit of allergy stickers on charts to assure the correct information was documented on the charts and MAR's. On 03/06/2013 the Data Entry LPN reviewed all I.V., I.M., and P.O. orders for antibiotics within the past 45 days; the orders were compared against the pharmacy records to assure that no orders had been missed. All MARs that included antibiotic orders were reviewed to assure medications were being given as ordered. The Assistant Director of Nursing inspected each medication room and refrigerator for expired, outdated or discontinued medications or those of residents who had been discharged to assure that only those medications appropriate for current use	

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F 333	Continued From page 7 but I don't remember checking the name (Resident)." "Q (question to nurse #1): Did you check for allergies?" The answer from nurse #1 was "Yes I checked for allergies when I was passing her medications." In an interview with the Administrator on 03/06/13 at 1 PM, she stated that nurse #1 had removed an IV fluid bag from the medication refrigerator and set the bag on the counter. Another bag of IV fluids was on the counter. Nurse #1 told the administrator that she stopped to talk to another staff member. When the conversation was finished, she picked up the wrong bag and saw "cillin" on the bag, went to Resident #1's room, hung the bag, and she never checked the resident's name against the bag of IV antibiotic. Review of the report to the Board of Nursing dated 02/28/13 revealed: "On 02/28/13, at approximately 8:00 (AM) Nurse (#1) obtained IV fluid bag with antibiotic from refrigerator in medication room and set it out on the counter. She was then interrupted by a co-worker asking her a question. She picked up the bag noting that she could see the letters "cillin" and took it to the room. She hung the bag, attached it to the patient and started the IV and flushed the peripheral site. Shortly after, the family arrived, looked at the bag noting that it did not have the correct resident's name on it, and (the family) immediately alerted the Director of Nursing. Upon observation the DON noted that it was the wrong patient name on the bag (Resident #2 not Resident #1), was Penicillin not [sic] Piparacillen and was expired. Additional Comments: IV medication administered was expired, wrong patient, wrong drug. However it [the medication	F 333	current use remained in the facility. The Pharmacy Consultant completed his monthly review of all charts to assure there were no additional errors or omissions. There were no additional errors found. Systemic Corrections: The Staff Development Coordinator completed re-training of all licensed staff on all shifts on the "Five Rights of Medication Administration". This training began on 02/28/2013 and was completed 03/09/2013. On 03/13/2013 the Pharmacy Consultant completed an in-service for licensed nurses on "Medication Administration 101" and specifically discussed the risks of medication error and/or omissions. The Director of Nursing initiated a new form for the night shift licensed nurses to perform weekly checks in the medication rooms to assure only medications appropriate for current use are in the facility. In addition, the Director of Nursing or designee will audit each medication storage area on a weekly basis x 3 months and then bi-weekly ongoing; to assure this corrective action is sustained. 100% of new written or telephone physician's orders are now reviewed in clinical rounds by a member of the clinical team on the next business day to assure all orders are completed; medications are matched against the MAR to assure correct transcription	

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F 333	Continued From page 8 that was hung] should have been removed from the refrigerator prior to the incident." The nurse was suspended pending investigation and terminated. A medication variance report was done and the incident was faxed to the N.C. Board of Nursing. The family removed the resident from the facility that afternoon and moved her to another skilled nursing facility in the area During the interview on 03/06/13 at 10:30 AM, the Administrator shared the copy of the IV bag label. The label had Resident #2's name. The label had the medication as "Penicillin GK (Pfizerpen), dose 3 mu (million units), Administer 106 ml over 30 minutes every 4 hours Intravenously." The label indicated the medication was dispensed from the pharmacy on 02/04/13 and that the medication expired on 02/11/13. When the Administrator was asked "why was this medication in the refrigerator?" she stated that it should have been sent back to the pharmacy when the treatment ended on 02/08/13. Record review of Resident #2's Medication Administration Record revealed several doses of Penicillin GK were not signed off as given by the nurses during the month of January, 2013. The Penicillin GK order was discontinued on 02/08/13 after the midnight dose. The doses that were not given were left in the refrigerator and inadvertently were given to Resident #1. 2. Resident #2 was admitted to the facility on 09/08/09 with diagnoses of dementia, arthritis and	F 333	Beginning 03/06/2013- Prior to any IV medication being administered, two nurses must now review the order, the medication, and sign off indicating a full review of the Five Rights: Right patient, right medication, right dose, right time, and right route in the resident's room. Sustained Compliance: Staff Development Coordinator will complete random medication administration observation with all licensed nurses and medication aides monthly x 3 months then re-evaluate. Each observation will include at minimum of 10 opportunities. These observations will be provided to the Director of Nursing for review in Performance Improvement for 3 months. The Staff Development Coordinator will re-educate the licensed nurses and medication aides; the re-education will be reflective of the outcome of the medication observations All corrective action will be tracked and trended with changes in procedure made as appropriate. The results of this tracking will be presented to the Process/Performance Improvement Committee and the Medical Director on a monthly basis for review in response to any negative outcomes. Date of Compliance Immediate corrective action was initiated on 02/28/2013. All corrective actions related to TAG 333 were completed by 3/22/2013.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-CYPRESS POINTE	2006 S 16TH ST WILMINGTON, NC 28401

(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 333	Continued From page 9 COPD (chronic obstructive pulmonary disease). On January 20, 2013 he was sent to the hospital with an altered mental status and metabolic encephalopathy. He returned from the hospital on 01/24/13 with a PICC line (peripherally inserted central catheter) suitable for giving intravenous antibiotics. Review of Resident #2's medical record revealed the physician gave an order on 01/25/13 for "Dextrose 5% 60 milliliters with Penicillin GK, Inject 3 million units (mu) into the vein every 4 hours for 10-14 days; followed by Benzathine Penicillin 2.4 million units intramuscularly (IM) weekly for 3 weeks." The medication was started on the 25th of January, 2013 and the order was clarified to discontinue the Penicillin GK on 02/08/13 (to give for 14 days). Review of the January 2013 Infusion Therapy Medication Administration Record (MAR) revealed that one of Penicillin GK dose was not signed off as given on 01/25/13 at 10 PM. One dose of Penicillin GK was not signed off as given on 01/28/13 at 2 PM. Two doses of Penicillin GK were not signed off as given on 01/30/13 at 2 AM and 6 AM. During an interview on 03/06/13 at 1 PM, an Administrative nursing staff could not explain if the Penicillin GK doses were missed or not signed off as given. Record review of the February 2013 MAR revealed that the two IM doses of Penicillin 22.4 million units [the second part of the hospital	F 333	Kindred Transitional Care and Rehabilitation Cypress Pointe take pride in providing excellent care to our Residents and takes any and all deficiencies extremely serious. We value the trust that the Residents and Families have shown in our facility to provide sage and quality care; our team will work together to assure that these deficiencies are corrected and maintained.	

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F 333	Continued From page 10	F 333		

ordered protocol] ordered to be given on 02/15/13, 02/22/13 and 03/01/13 were also not signed off as given.

Observation of the refrigerator on the unit on 03/06/13 at 1 PM revealed no penicillin IV or IM medication in the refrigerator.

On 03/06/13 at 12:41 PM, the pharmacy faxed a signed statement which stated, "Order for Penicillin IM not received at [name of pharmacy] on or after 01/24/13 for (Resident #2). The statement was signed by one of the pharmacists of the vending pharmacy.

During an interview with the administrator on 03/06/13 at 1 PM, she said pharmacy staff told her they never got the order for the three IM doses of 2.4 mu of Benzathine Penicillin although it was clearly marked on the discharge orders, so the three doses of Benzathine Penicillin were never sent to the facility. The pharmacy had no record of any nurses calling them on the 15th of February, 2013 to say they did not have the medication.

During an interview with the ADON on 03/06/13 at 11:10 AM, she stated she consulted with the nurse practitioner (NP) on site and she (NP) stated they should get the penicillin IM and administer it.

During an interview with the ADON on 03/06/13 at 2 PM, she stated she called the attending physician who stated he wanted another laboratory test done before the IM Penicillin was started to evaluate whether the missed doses should be resumed after the break in the

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F 333	Continued From page 11 protocol.	F 333		