STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CARE & REHABILITATION CENTER	604 STOKES STREET EAST AHOSKIE, NC 27910

(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 staff interviews, the facility failed to ensure an prescribed medication was obtained from the pharmacy for 7 days after it was ordered for 1 (resident #1) of 3 residents reviewed for pharmacy services. Findings included: A review of the facility policy dated 2007 titled "3.12 Medication Shortages" reads the facility nurse must make every effort to ensure that a medication ordered for the resident is available to meet their needs.	F 425	1a-Resident #1 no longer has any omitted medications. Medications have been obtained and are administered as ordered. 1b-MAR/TAR audit performed by ADON for any omitted medications or circled medications on MAR. 2-Nurses currently employed who omitted medication administration have been counseled with. 3-SDC will educate nurses on the correct process to follow if medications are not available. 4-Evelyn May, Administrator, met with Stephanie Bullock, Pharmacy Director, to discuss medication delivery process and use of back up pharmacy when needed. Pharmacy In service for nursing staff presented by Mrs. Bullock, is scheduled for 4/7/14. 5-DON, ADON, and SDC audited residents' MARs and TARs to ensure	4/11/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Evelyn J. May — TITLE: Administrator — (X6) DATE: 3/28/14

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 Resident #1 was admitted to the facility on 6/28/14 with cumulative diagnoses of cerebral vascular accident (CVA) dysphagia, congestive heart failure, atrial fibrillation, depression and dementia. The most recent Minimum Data Set (MDS) was a significant change MDS dated 3/1/14. It indicated resident #1 was not cognitively intact and required total assistance with her activities of daily living (ADLs). A review of the physician orders revealed an order dated 1/16/14 for an Exelon patch daily. The Exelon patch was prescribed for treat the symptoms associated with Alzheimers and memory loss. The original physician order was signed off by the nurse working 2nd shift on 1/16/14. The order was transcribed onto the medication administration record (MAR) for January 201.4. A review of the January 2014 MAR indicated that resident #1 did not receive the Exelon patch on 1/17/14, 1/18/14, 1/19/14, 1/22/14 and 1/23/14. It was initialed as given on 1/20/14 and 1/21/14. In an interview on 3/19/14 at 9:30 AM, the assistant director of nursing (ADON) provided a photocopy of the order dated as received at the pharmacy on 1/23/14. The ADON stated she was unaware that the order was not faxed to the pharmacy until 1/23/14. The ADON stated the nurse who signed off on the order 1/16/14 was no longer employed at the facility. The night shift nurse audits the charts nightly to make sure there are no orders not taken off the charts and checks to ensure any new orders are added to the MAR or the treatment administration record (TAR). The ADON was unable to answer why the order was not faxed on 1/16/14 or why the floor nurses did not follow up on the missing medication.	F 425	medications have been obtained and are being administered as ordered. 6a-Biweekly audits will be conducted by DON,ADON, Unit Manager and SDC to ensure medications are obtained timely. 6b-The results of audits will be brought to monthly Performance Improvement meetings monthly for 3 months. Audits will be reviewed, and any necessary performance improvement processes put in place.	

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F 425	Continued From page 2 In an interview on 3/19/14 at 10:12 AM, nurse #1 stated her circled initials 1/19/14 on resident #1 MAR for the Exelon patch indicated she did not apply the patch. Nurse #1 stated the medication was not available in the medication cart with the rest of resident #1's medications. Nurse #1 stated she only started at the facility recently and was not aware she should have contacted the pharmacy to inquire about the missing medication. Nurse #1 stated she did not notify the pharmacy, her supervisor or the physician of the lack of medication. In an interview on 3/19/14 at 10:38 AM, nurse #2 stated the nurse who took the order off was no longer working at the facility. Nurse #2 stated if the order was faxed on 1/16/14 before 5:00 PM, the medication would have been at the facility on 1/17/14. Nurse #2's circled initials on the MAR for 1/17/14 indicated she did not have the medication to administer. Nurse #2 stated she did not contact the pharmacy to see if the Exelon patch would be delivered 1/17/14. Nurse #2 stated she did not report the missing medication to the pharmacy, her supervisor or the physician. Nurse #2 stated she worked again on 1/20/14 and the Exelon patch was still not available for resident #1. Nurse #2 stated she borrowed the Exelon patch from another resident on 1/20/14 and called the pharmacy. Nurse #2 stated she could not recall who she spoke with and she did not document her follow up with the pharmacy. Nurse #2 stated she again worked on 1/21/14 and had to again borrow another Exelon patch from another resident for resident #1. Nurse #2 stated she did not follow up with pharmacy on 1/21/14. Nurse #2 stated she did not inform her supervisor or the physician about the missing medication.	F 425		

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F 425	Continued From page 3 A review of the January MAR indicated another nurse who worked 1/23/14 also circled her initials for the Exelon patch indicating that the medication was not administered. The ADON confirmed this nurse was not longer employed at the facility. In a telephone interview on 3/19/14 at 10:50 AM, the pharmacist stated she was contacted 3/18/14 to provide evidence of when the pharmacy received the order for the Exelon patch for resident #1. The pharmacist stated the first time the pharmacy received the order was 1/23/14. The pharmacist stated there was no record of any telephone calls from the facility inquiring about the need for the Exelon patch. She stated anytime a medication was unavailable, the staff should contact the pharmacy to ensure the pharmacy received the order and apparently that did not occur in the case until 1/23/14 when the order was faxed. The pharmacist said is most cases, if an order was faxed after 5:00 PM, it would arrive the same day with the night delivery. It would certainly arrive by the next day if the order was faxed too late for delivery on the same day. The pharmacist stated if a medication was not readily available and needed immediately, the pharmacy can and does contact a local pharmacy to deliver the prescribed medication. In a telephone interview on 3/19/14 at 11:24 AM, nurse #3 who worked 1/22/14 indicated if her initials were circled on the January MAR, she did not administer the medication. Nurse #3 did not recall writing on the back of the January MAR that the Exelon patch was unavailable but stated if she wrote it, it must have been the case. Nurse #3 stated if the Exelon patch was not available	F 425		

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F 425	Continued From page 4 that day, she should have contact the pharmacy to find out if the pharmacy ever received the original order. Nurse #3 was unable to recall if she notified the pharmacy, her supervisor, or the physician. In an interview on 3/19/14 at 11:40 AM, the administrator stated her expectation would have been for the nurses to have followed up on the missing medication immediately when it was discovered as not available. In a telephone interview on 3/19/14 at 12:30 PM, the physician stated his expectation would be for staff to follow up with the pharmacy if a prescribed medication was not available once the mediation was identified as missing.	F 425		