STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING ______ B. WING ______	C 06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CLEMMONS	**3905 CLEMMONS ROAD CLEMMONS, NC 27012**

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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 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 record review, Hospice Nurse interview, Hospice Case Manager interview, Physician interview, Pharmacist interview and staff interviews, the facility failed to administer	F 755	The medication error for resident #2 occurred because the written order was not entered into the electronic health record upon receiving the order, and the	6/27/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/13/2018

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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medications as ordered by the physician for two of eleven residents who were reviewed for pharmacy services and/or were observed for medication pass (Resident # 2 and Resident # 14).

Findings included:

1. Resident #2 admitted to the facility from hospice care at home on 5/15/18 with diagnoses of Lung Cancer with Malignancy, Anxiety, Depression, Hypertension, Urinary Obstruction, and right arm fracture. The Admission Minimum Data Set Assessment dated 5/22/18 revealed he was moderately cognitively impaired; and he required extensive assistance with moving transferring to and from the bed and toileting.

A urinalysis obtained on 5/13/18 before Resident #2 was admitted to the facility, but was under the care of hospice at home, was included in the medical record and showed the resident had a Urinary Tract Infection. The facility received the results of the urinalysis from hospice on 5/18/18.

Review of Hospice Nurse Note dated 5/18/18 noted the Nurse Practitioner was called and gave orders to start Keflex 500 milligrams by mouth 1 tablet twice daily for 7 days for a Urinary Tract Infection.

A review of the May 2018 Medication Administration Record revealed Resident #2's antibiotic for a Urinary Tract infection, Keflex, was not started until 5/21/18.

An interview on 6/19/18 at 2:10 pm with the Unit Manager, Nurse #1, revealed she had taken a written physician's order from the Hospice Nurse on Friday 5/18/18 for Keflex 500 milligrams by

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other clinical staff that were working with resident were not aware the order had been written. Resident #2 received his initial dose of Keflex on 5-21-2018 when Medication error was recognized and the MD was notified resulting in an order to clarify/rewrite the order with a start day of 5-21-2018. The new order was properly entered into the electronic health record and medication administration record. RP aware of the medication error.

The medication error for resident #14 occurred because the clinical staff that were working with resident failed to follow up with the pharmacy to ensure timely delivery of medication. Resident #14 received a one-time dose of the Breo Ellipta, per the MD order, on 6-20-2018 at 12:05, when the medication was delivered from the pharmacy. Medication resumed on prior schedule on 6-21-2018. MD and RP aware of error. Nurses/MA were in-serviced on the medication ordering process on 7-6-18 by the DON with emphasis on obtaining medications through the backup pharmacy and nurses were in-serviced on order transcription as well.

All resident’s medication administration records were reviewed and audited by DON,
Comparing the MAR to physician’s orders on 6-21-18 and 6-22-18 to ensure medications were available for residents. On 6-25-18 and 6-26-18 the DON audited all ‘hard’ charts, with added emphasis placed on Hospice charts, to ensure all

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mouth 1 tablet twice daily for 7 days for a Urinary Tract Infection. She stated she did not work the next two days, which were a weekend. When she returned to the facility on Monday, 5/21/18, she stated the Keflex had not been started. Nurse #1 stated she did not know what had happed to the written order and she didn't know why it was not entered into the electronic record on 5/18/18. Nurse #1 stated she entered the order in the computer on 5/21/18.

An interview on 6/19/18 at 2:55 pm with the Director of Nursing revealed her expectation is all medications should be given as ordered and started timely. She stated she was not aware Resident #2 had missed doses of Keflex. The Director of Nursing stated the Unit Managers or the Nurse responsible for the resident could put the orders into the electronic system. She stated that the nurse that took the order should have entered it into the electronic system.

An interview with the Hospice Nurse on 6/19/18 at 12:55 pm revealed she had visited Resident #2 on 5/18/18. She stated during the visit she spoke with the Nurse Practitioner and obtained a verbal order for Resident #2 to have Keflex 500 milligrams by mouth 1 tablet twice daily for 7 days. She stated she had written the order on a telephone order form and gave it to the Unit Manager, Nurse #1.

During a telephone interview with the Physician on 6/20/18 at 10:05 am he stated Resident #2 would not have been harmed by the delay of the antibiotic for two days. He stated his expectation would be all medications would be given as ordered.

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orders had been transcribed and delivered accordingly. No outstanding orders were noted. The facility was in full compliance effective 6-27-18.

The plan to create a new system with maximized sustainable compliance includes the Unit manager perform audits on all medication carts beginning on 7-5-18 and 7-6-18 for medications, cleanliness, expired medications and unnecessary medications, which were removed from carts. Cart Audits will be performed at least weekly to ensure compliance, new orders are checked, as well as refill orders during this audit.

Additionally, to ensure that refill medications are addressed as well as new orders, the following measures have been put into place: The nurses have been in-serviced to report off each shift the time that each refill has been ordered. If there is a refill that has not been filled during the shift the nurse needs to notify the DON/Designee so that they can follow up with pharmacy or check Omniview. The facility is working to obtain Omniview access for all of the nursing staff so they can request refills via the scanner wand that was provided by Omnicare. Until all nursing staff is well versed in scanning their refill requests and tracking their refill requests on Omniview, the DON/Designee will continue to check Omniview daily to ensure medication availability.

There has also been a communication

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F 755	Continued From page 3 On 6/20/18 at 1:20 pm during a follow up interview with the Unit Manager, Nurse #1, she stated the Hospice Nurse had given her the written physician's order for Resident #2 on 5/18/18 for Keflex 500 milligrams by mouth 1 tablet twice daily for 7 days for Urinary Tract Infection but she did not know what happened to the written order. Nurse #1 stated the order must have been misplaced. She stated she was the person that put all the orders into the electronic system and when they are entered into the computer she signs the copy of the order. Unit Manager, Nurse #1 was not able to explain what had happened to the order she received on 5/18/18 for the antibiotic. 2. Resident # 14 was readmitted to the facility on 03/10/2017 with diagnoses including but not limited to: Alzheimer's Disease, Parkinson's Disease, Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus Type II, hemiplegia, and stroke. Review of a Quarterly Minimum Data Set (MDS) assessment dated 03/21/2018 indicated that Resident # 14 was cognitively intact. Medications administered during the assessment period included 7 days of injections, insulin, antipsychotics, antidepressants, and opioids. A review of the physician orders for Resident # 14 revealed an order dated 06/17/2017 for fluticasone furoate - vilanterol aerosol powder 100/25 microgram inhaler - Inhale 1 puff orally one time a day for COPD, rinse mouth after each dose. Fluticasone furoate - vilanterol aerosol	F 755	book placed in the DON office that allows for nurses from hospice to communicate if a new order or refill has been ordered. Furthermore, the DON/Designee will run a daily report of new orders that have been entered into PCC, compare new orders to the delivery sheet from Omnicare to ensure medication availability. This will be an ongoing practice for the facility. DON/Designee will run a Medication Administration Audit report daily, while in the clinical meeting, to ensure no medications were overlooked by the clinical team. DON/Designee will check 'hard' charts every day for missed orders until 8-1-18 or until 'hard' charts are retired. Another way to maintain compliance is to arrange for an Omnicell to be placed in the facility. The Omnicell will have numerous medications that are commonly used by this population and it will allow for more timely medication administration for the residents. It will also ensure accountability with the clinical staff. Omnicell room established and provisions/renovations were completed on 7-12-18. Facility anticipates going live with Omnicell no later than 8-1-18. Facility will continue to obtain medications, which are needed stat or after hours, through the CVS backup pharmacy until Omnicell is live. All audits will be presented to QAPI for monitoring for a period of 6 months beginning with the July meeting. At the end of 6 months, the process will be	

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F 755	Continued From page 4 powder 100/25 microgram inhaler, also known as Breo Ellipta, is a prescription medicine used long term to treat chronic obstructive pulmonary disease. On 06/20/2018 at 8:55 am an observation was done of a medication pass with Medication Aide (MA) # 1. MA # 1 was observed to pull medications for Resident # 14. MA # 1 was unable to locate Resident # 14's fluticasone furoate - vilanterol aerosol powder 100/25 microgram inhaler in the medication cart. MA # 1 indicated that she recalled requesting a refill for this medication but since it was not in the cart the pharmacy must not have sent it. MA # 1 indicated that she would check the medication room to make sure the inhaler was not there. At 8:59 am MA # 1 revealed that she was not able to locate the medication in the medication room and she had let her supervisor know the medication was not available in the facility. A review of the Medication Administration Record (MAR) for June 2018 revealed the fluticasone furoate - vilanterol aerosol powder 100/25 microgram inhaler was scheduled for 9:00 am each day and was not administered on 06/13/2018, 06/18/2018, 06/19/2018, and 06/20/2018. A nursing note dated 06/13/2018 at 1:31 pm made by MA # 1 stated medication (fluticasone furoate - vilanterol aerosol powder 100/25 microgram inhaler) was on hold until received from pharmacy. A nursing note dated 06/18/2018 at 9:25 am made by MA # 1 stated medication (fluticasone furoate - vilanterol aerosol powder 100/25	F 755	reviewed and the QAPI committee will determine whether to continue current processes or revise the process as needed. The DON is responsible for the ongoing compliance with this corrective action which will be completely implemented by 6/27/2018.	

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microgram inhaler) was on hold until received from pharmacy.

Review of a package insert, found on the drug manufacturer's website, revealed that the medication "should be used at the same time every day."

On 06/20/2018 at 10:20 am an interview was conducted with Resident # 14's physician. He indicated that the inhaler was used for the long-term control to keep the resident from having a COPD exacerbation (a worsening of symptoms). He reported that the resident had mild COPD that was currently stable. He indicated that if Resident # 14 had not had an exacerbation then missing her dose did not have any negative consequences. The physician indicated that he felt missing those few doses would not cause any harm, but the medication should be restarted. He stated his expectation would be all medications would be given as ordered. The physician indicated he had not spoken with anyone at the facility regarding these missed doses.

On 06/20/2018 at 11:05 am an interview was conducted with MA # 1. MA # 1 indicated that she reordered Resident # 14's inhaler on 06/13/2018 and again on 06/18/2018. MA # 1 provided a fax confirmation dated 06/18/2018 at 11:58 am that indicated the fax transmission results were OK that included a request for Resident # 14's fluticasone furoate - vilanterol aerosol powder 100/25 microgram inhaler. MA # 1 indicated if she ordered a medication and she was aware it did not come in she would call the pharmacy to check on the medication or she would let her supervisor know so they could call to make sure

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the resident had their medication.

On 06/20/2018 at 11:17 am an interview was conducted with Nurse # 1. Nurse # 1 reported that the physician was notified today, 06/20/2018, that Resident # 14's medication was not available. Nurse # 1 indicated the physician ordered a one-time dose of the inhaler, to be given when the medication arrived at the facility today, 06/20/2018, and instructions to resume the normal dosing schedule tomorrow (06/21/2018). Nurse # 1 indicated that if something was ordered from the pharmacy and the pharmacy does not send the medication they are supposed to notify the facility why the medication was not sent. Nurse # 1 reported that she called the pharmacy on 06/20/2018 regarding Resident # 14's inhaler and there was no reason that they did not send the inhaler. Nurse # 1 indicated that the pharmacy did not know what medication she was asking for when she asked for fluticasone furoate - vilanterol aerosol powder 100/25 microgram inhaler. Nurse # 1 indicated that the medication was also known as Breo and that was how the pharmacy had the inhaler listed. Nurse # 1 reported the pharmacy asked when the inhaler was needed and she indicated it had been due at 09:00 am on 06/20/2018. She indicated the pharmacy would send the inhaler with this morning's, 06/20/2018, delivery and it would be delivered by lunch time. Nurse # 1 reported that the pharmacy can be very difficult and if the facility has not stayed on top of the pharmacy the facility has had problems with receiving medications. Nurse # 1 indicated that they do not always receive the medications that orders and requests have been sent for. Nurse # 1 indicated that when the facility calls to check on the status of a medication order they have been "constantly

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told the pharmacy did not get what we sent." Nurse # 1 indicated that the Director of Nursing (DON) was aware of these issues and had been in communication with the pharmacy representative regarding these issues.

A nursing note dated 06/20/2018 at 12:03 pm made by MA # 1 stated medication (fluticasone furoate - vilanterol aerosol powder 100/25 microgram inhaler) was on hold until received from pharmacy. Pharmacy sending medication on morning delivery. Resident will be given a one-time dose today per MD (Medical Doctor) and start regular dose at 9 am tomorrow.

A review of the physician orders for Resident # 14 revealed an order dated 06/20/2018 for fluticasone furoate - vilanterol aerosol powder 100/25 microgram inhaler - Inhale 1 puff orally one time a day for COPD, rinse mouth after each dose and inhale 1 puff orally one time for COPD until 06/20/2018 at 11:59 pm. Please provide resident with inhaler when arrives from pharmacy today.

On 06/20/2018 at 12:12 pm an interview was conducted with the Director of Nursing (DON). The DON indicated it would be her expectation that when the facility reordered medications from the pharmacy that the medication would be sent to the facility so the resident received their medication or that the facility would be notified the medication was not sent.

On 06/20/2018 at 1:01 pm an interview was conducted with a Doctor of Pharmacy (PharmD) from the facility's pharmacy. The PharmD indicated that the medication was delivered to the facility around lunch time today. The PharmD

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indicated that she spoke with the facility's account manager and the pharmacy was not able to locate the reorder request that the facility faxed over on 06/18/2018 for Resident # 14 and there were no notes to indicate someone called to request this medication on 06/18/2018. The PharmD indicated the pharmacy had not been able to locate any communication regarding Resident # 14 from the facility for 06/18/2018. The PharmD was provided with the date and time that was listed on the fax confirmation sheet provided by the facility. The PharmD verified that the fax number listed on the fax confirmation sheet was the correct fax number for the pharmacy. The PharmD indicated that the pharmacy planned to review their server, fax by fax, too see if the pharmacy can determine what happened. The PharmD revealed that she had reviewed Resident # 14's records, including her MAR and notes. The PharmD indicated the resident had missed doses on 06/18/2018, 06/19/2018, and 06/20/2018. The PharmD indicated that she looked up the fluticasone furoate - vilanterol aerosol powder 100/25 microgram inhaler in her pharmacology resource book and learned that it takes 6 days for this medication to reach a stable dose in the body and lungs. The PharmD indicated that if Resident # 14 missed three days of this medication there could potentially be issues with the control of Resident # 14's COPD symptoms. The PharmD indicated that she had reviewed Resident # 14's MAR and notes and they revealed that she had not received any of her as needed medications for COPD symptoms and there was no indication that she was having issues with the control of her symptoms over the past few days.

On 06/20/2018 at 1:30 pm an interview was

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F 755	Continued From page 9 conducted with the Administrator. The Administrator indicated that if a medication was not available on the medication cart and there was documentation that the medication had already been reordered, staff should call the pharmacy and follow up. The administrator indicated that the same nurse does not always work the same cart everyday but if the next nurse does not see the medicine her expectation would be that the nurse call to find out what the disconnect was. The nurse would be expected to determine if the issue was on the pharmacy's end or on the facility's end so the medication is delivered to the facility as soon as possible. When an order is faxed to the pharmacy, the staff should wait to receive a confirmation the fax was received by the pharmacy. The Administrator would expect that the pharmacy would call if there were a problem with refilling an order so the facility can address any issues immediately so the resident's get their medication on time. The Administrator further indicated that when the facility faxes over a refill order her expectation would be that the pharmacy would fill the request in a timely manner so the residents have their medication. The Administrator also indicated that all medications should be given as ordered by the physician in a timely manner.	F 755		