STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0454	A. BUILDING: ______ B. WING ______	10/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, I	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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) COMPLETE DATE
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record review and staff interviews the facility failed to assure an antibiotic was administered correctly for one (Resident # 1) out of four sampled residents. The findings included: Record review revealed a surgeon had been consulted since 9/19/16 regarding the care of an abscess on Resident # 1 ' s back. According to physician orders the resident had been prescribed different antibiotics to treat the abscess. On 10/5/16 there was a physician ' s order that the resident should receive Doxycycline 100 mg (milligrams) every day for 30 days for the abscess. Review of the resident ' s October 2016 MAR (Medication Administration Record) revealed the daily Doxycycline was due to be administered at 10 PM. On 10/22/16 at 7:33 PM Medication Technician (MT) # 1 documented the Doxycycline was not available and not administered that day. On 10/23/16 at 9:42 PM Medication Technician # 2 documented the medication was not given and that the facility was " waiting on pharmacy. " Interview with the administrator on 10/27/16 at 5:30 PM revealed the missed antibiotic doses had not been reported to anyone, and she had not been aware of the medication omissions. MT # 2 was interviewed on 10/27/16 in regards to	D 358	1. MD was notified of missed antibiotic and extended length of ABT therapy for 2 days. Resident#1 was administered ABT as ordered on 10/27/16 as ordered by the Medication Technician. 2. Resident #1 was assessed by the charge nurse on 10/27/16 and no negative findings were noted. Resident's abscess site showed continued signs of improvement. 3. Resident had a follow-up with the general surgeon on 11/2/16, and MD stated area almost resolved,antibiotic therapy ordered for 30 more days. 4. Family was notified by the charge nurse of new orders on 11/2/16. 5. Audit of resident medication administration record conducted by the Administrator on 10/31/16 and no missed doses of antibiotics were found. All other findings addressed by the DNS with appropriate staff. 6. Cart audit was completed by the Unit Coordinator and RN Supervisor, 11/28 and 11/29/16 to ensure all prescribed medications were on the cart and readily available for administration.	11/19/16

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D 358	Continued From page 1 the missed 10/23/16 dose. The administrator was present during the interview. MT # 2 stated she did not normally work on the unit where Resident # 1 resided. MT # 2 stated on 10/23/16 she had been called to replace MT # 1 in the middle of the shift because MT # 1 needed to leave early. MT # 2 stated during the transition of the assignment, MT # 1 reported Resident # 1 ' s Doxycycline had been ordered and had not been received. MT # 2 confirmed she did not give the Doxycycline on 10/23/16 and stated she did not consult a licensed nurse about the missing medication. The administrator stated she would clarify why MT # 1 had not given the antibiotic the previous day. On 10/31/16 at 12 PM a follow up interview was conducted with the administrator. The administrator stated she had discussed the missed 10/22/16 Doxycycline dose with MT # 1. The administrator stated she confirmed MT # 1 did not give the Doxycycline on 10/22/16. The administrator stated the omission reason, which was given by MT # 2, was the unavailability of the medication. The administrator stated the facility ' s system always allowed for medications to be available. The administrator stated Doxycycline was an antibiotic which was stored in the facility ' s emergency medication supply. The administrator stated the Medication Technicians were supposed to consult with their charge nurse and report any missing medications so they could be obtained from back up. The administrator stated Resident # 1 ' s Doxycycline had been available on both days it was omitted and the medication technicians had failed to consult with the licensed nurse to obtain the medication from the back up supply.	D 358	7. Medication technician #1 no longer employed with the facility effective 11/29/16, medication technician #2 was in-serviced and all other medication technicians were in-serviced on 10/28/16 and 10/28/16 by the facility administrator on the Proper Procedure for Obtaining Medication from the pharmacy. 8. Medication technicians not in-serviced by 11/7/16, will be removed from the schedule by the DNS as a medication technician until training is complete. All new hires for Medication Technicians will be in-serviced on the Proper Procedure for Obtaining Medications from the Pharmacy upon hire by the SDC. 9. Medication Pass Observations were completed on all medication techniques by a licensed RN pharmacy consultant on 11/10/16 to ensure accuracy with medication administration. Findings noted and addressed by the DNS. 10. Medication aides will call back-up pharmacy if medication is unavailable. If medication unable to be obtained from pharmacy, the MD will be notified by the charge nurse for further recommendations or medication changes 11/11/16. 12.Medication cart will be audited weekly x 60 days and every 30 days thereafter by the DNS or designee to ensure medications are accessible and available as of 11/11/16. 13. MAR's will be audited weekly x 60 days, and monthly thereafter to ensure compliance by the DNS/designee to ensure compliance. Findings will be addressed and documented on the Weekly MAR audit sheet and findings will be addressed with appropriate personnel.	

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D 358	Continued From page 2	D 358	Results will be taken to the Quarterly QA Committee to monitor for compliance. Changes will be made to the plan as deemed appropriate by the QA committee 11/11/16. 14. Random medication observation passes will be conducted by the DNS/RN designee monthly and findings documented on the Medication Administration Compliance Report. 11/10/16 and thereafter 15. Findings from audits and medication compliance reports will be submitted to the monthly QA Committee monthly and changes will be made to the plan as deemed necessary by the Committee 10/31/16 and thereafter.	