

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345395	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/23/2014
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES-CHERRYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021		
(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	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to follow facility policy for ordering medications for 1 of 3 residents. (Resident #1). Findings included: Review of the facility policy Medication Ordering and Receiving dated 03/01/11 revealed: New medications, except for emergency or " stat " medications, are ordered as follows: If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request medication to be called in to the backup pharmacy.</p>	F 425	<p>Filing the plan of correction does not constitute admission that the deficiencies alleged did in face exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.</p> <p>F425 Resident #1 was discharged home on 10/2/2014 with medications sent home with resident. For all residents, 100% of all medications were audited to ensure that all residents</p>	11/20/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/13/2014

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	<p>Continued From page 1</p> <p>Resident # 1 was admitted to the facility on 09/30/14 with diagnoses of restless leg syndrome, chemical burn due to allergy, aftercare following joint replacement, and congestive heart failure.</p> <p>A review of a physician order dated 09/30/14 revealed an order for levothyroxine 137 micrograms (mcg) once a day, Mirapex 0.5 milligram (mg) twice a day, and rapaflo 8 mg once a day.</p> <p>A review of the Medication Administration Record (MAR) dated 09/30/14 -open ended revealed that on 10/01/14 the levothyroxine 137 mcg, Mirapex 0.5 mg, and rapaflo 8 mg were not administered as ordered with a comment on the MAR of awaiting pharmacy, drug/item unavailable, new resident, and meds not in from pharmacy.</p> <p>A telephone interview with Medication Nurse # 1 on 10/23/14 at 11:44 AM revealed she was the nurse responsible for administering medications for Resident # 1 on the day of 10/01/14. She verified she did not administer the Mirapex 0.5 mg, nor the rapaflo 8 mg as per physician ' s order due to the fact the medications had not been delivered from the pharmacy. She further revealed she did not call the pharmacy to notify them the medications had not arrived at the facility.</p> <p>A telephone interview with Medication Nurse # 2 on 10/24/14 at 11:42 AM revealed she was the nurse responsible for administering medications ordered for Resident # 1 that were ordered for 6:30 AM administration on the day of 10/01/14. She verified she did not administer the levothyroxine 137 mcg as per physician ' s order due to the fact the medication was not in from pharmacy. She further revealed she did not call the pharmacy to notify them the medication was needed.</p>	F 425	<p>had all medications as ordered by the physician.</p> <p>11/2/2014</p> <p>Education was provided to all nurses and medication aides by the Staff Development Coordinator/ Director of Nursing regarding the Medication Ordering and Receiving policy from Medipack Pharmacy. Any staff member on leave of absence will be educated prior to beginning work.</p> <p>10/23/2014</p> <p>An audit tool was developed to include if medications were received from the pharmacy in a timely manner for new admissions; if not received, was the facility policy followed for notifying the pharmacy and medication requested from the backup pharmacy. 100% of all new admissions will be audited for compliance with following the Medication Ordering and Receiving policy. Audits will be completed by the Director of Nursing or RN Supervisor weekly for 8 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring.</p> <p>11/14/2014</p> <p>All audit information will be analyzed and reviewed by the Director of Nursing at the QA Committee Meetings.</p> <p>11/20/2014</p>		

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

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F 425	Continued From page 2 A telephone interview with the pharmacy tech on 10/23/14 at 11:24 AM revealed the admit orders for Resident # 1 were generated at 5:55 PM on 09/30/14 and no calls were received from nursing staff at the facility to notify the pharmacy that the medications were needed before regular delivery time, nor did the pharmacy receive a phone call from the nursing staff at the facility the next day to notify them the medications were needed from the back up pharmacy. An interview with the Physician on 10/23/14 at 12:10 PM revealed that missing one dose of levothyroxine, mirapex, or rapaflo would not cause any immediate side effects as these medications are for chronic conditions. An Interview with the Director of Nursing (DON) on 10/23/14 at 4:15 PM verified levothyroxine 137 mcg, mirapex 0.5 mg, and rapaflo 8 mg had not been administered to Resident # 1 on 10/01/14. She further verified it is her expectation of staff to follow physician ' s orders, and the facility protocol for Medication Ordering and Receiving.	F 425			