STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 09/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH REHABILITATION CENTER	616 WADE AVENUE RALEIGH, NC 27605

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to consult with the physician to obtain new treatment orders	F 157	F - 157 The statements included are not an admission and do not constitute	10/18/16

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

Electronically Signed | 10/03/2016

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F 157	Continued From page 1 regarding unresolved skin problems for one (Resident # 11) out of nine sampled residents reviewed for change in condition. The findings included: Record review revealed Resident # 11 was initially admitted to the facility on 5/29/98. The resident had diagnoses of cerebral palsy, dysphagia, and a history of gastrostomy tube placement. Review of the resident ' s last MDS (Minimum Data Set) assessment, dated 8/29/16, revealed the resident was totally dependent on staff to meet his hygiene and bathing needs. The resident was also coded as having unclear speech. The resident ' s care plan, last reviewed on 8/24/16, revealed the facility had identified the resident was at risk for skin problems. The care plan directed that weekly skin assessments were to be completed. Review of the resident ' s physician progress notes revealed the last time the resident was seen by his physician was on 7/14/16 and there was no notation the resident had skin problems at that time by the physician. Review of the nursing notes revealed on 8/7/16 the nurses identified the resident had a boil under his left arm and a telephone order was given to the nurses to administer an antibiotic twice per day for a week. On 8/11/16 a nurse noted under a " weekly skin check " that the resident continued on an antibiotic for a left axilla abscess. There was no notation of other skin problems in the 8/11/16 skin assessment. On 8/18/16 a nurse noted the resident ' s buttocks and scrotum were red and that she applied Zinc as ordered. On 8/25/16 a nurse documented under the weekly skin check " zinc oxide to buttocks. " On 9/1/16 a nurse noted under the " weekly skin check "	F 157	agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. Interventions for affected resident: On 09/19/16, the Physician was notified of Resident #11 redden buttocks/scrotum area. A new order was obtained from the Physician for Nystatin powder daily to affected areas for two weeks. Interventions for residents identified as having the potential to be affected: By 10/18/2016, facility residents with current skin impairments will be evaluated by the facility Wound Nurse or Unit Manager to determine appropriateness of treatment. If treatment changes are warranted, the physician will be notified of change in condition and new orders will be obtained as appropriate. Systemic Change: By 10/18/2016, the facility Staff Development Coordinator will educate all Licensed Nurses on the facility Wound Management Program with emphasis on	

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F 157	Continued From page 2 that the resident ' s buttocks and scrotum were red and treatment continued as ordered. On 9/8/16 under the " weekly skin check " the only notation was " continues with butt cream with each brief change. " On 9/15/16 under the weekly skin check the nurse ' s only notation was " buttock red treatment cont. (continues) as ord. (ordered). " On 9/17/16 a review of the resident ' s August and September TARs (treatment administration records) revealed the only treatment the resident had been given for his red buttocks and scrotum during August and September was an application of Desitin Cream. There was no evidence the nurses consulted with the physician to change the course of treatment. The resident was observed on 9/17/16 at 10:30 AM as NA # 1 provided incontinent care to the resident. The resident appeared to have a redness in his groin and scrotum which resembled a rash. The resident ' s groin and scrotum were a bright red color. A large area of the resident ' s buttocks were very red. There were blotchy red areas on the resident ' s back also. When NA # 1 wiped with the cleansing wipe down the resident ' s right groin during the care, it was observed that there was a small streak of blood on the wipe. NA # 1 stated the resident scratched. The NA was asked how long the resident ' s skin had been in the condition observed and stated it had been like that about a month on and off, but it seemed to have started when he had the boils under his arms. The NA applied a barrier dimethicone cream and reapplied the resident ' s disposable brief. On 9/17/16 at 4:45 PM Nurse # 5, who was assigned to care for the resident from 7 AM to 7 PM, was interviewed. Nurse # 5 stated no one had mentioned the resident had a redness that	F 157	notifying the Physician for treatment changes if wound deteriorates or does not respond to prescribed wound treatment plan. Weekly for three (3) months, a skin assessment will be performed by the Director of Nursing, Assistant Director of Nursing or Unit Manager on (3) residents with a current skin impairment to assess appropriateness of current treatment plan. The Physician will be updated on any change in condition if noted and new orders obtained as appropriate. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 157	Continued From page 3 resembled a rash. On 9/17/16 at 4:55 PM the treatment nurse was interviewed and also stated no one had mentioned to her that the resident appeared to have redness that resembled a rash. The treatment nurse stated she would go observe the resident ' s skin at that time. The treatment nurse was accompanied to the room. The resident was again observed to have light splotchy red areas on his back. His scrotum, groin, and buttocks were a deep reddened color. Upon observation with the treatment nurse it could be seen that the redness extended down the resident ' s inner thigh areas also. Under the resident ' s left arm there was redness. The treatment nurse stated the physician would be in during the AM and she would request the physician to evaluate the resident. A follow up interview was conducted with Nurse # 5 on 9/19/16 at 12:07 PM. Nurse # 5 stated the physician had not come in that morning, but the treatment nurse had called the previous evening following her observation with the surveyor and talked with the physician. Interview with Nurse # 5 revealed that following the treatment nurse ' s communication, the physician decided to place the resident on a medication for the skin problem. The resident had been ordered to receive Nystatin powder to the affected areas for two weeks.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		10/18/16

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F 281	Continued From page 4 Based on observation, record review, resident interviews, and staff interviews the facility failed to transcribe and administer two medications as ordered for one (Resident #24) of five residents who were reviewed for medication administration. The findings included: 1a. Record review revealed Resident # 24 was initially admitted to the facility on 6/9/15. The resident had multiple diagnoses. These included diagnoses of chronic obstructive pulmonary disease, history of pneumonia, depression, and anxiety. Review of a neuropsychiatry consult, dated 8/18/16, revealed the resident reported she was feeling " more sad " and her " appetite was poor. " Review of the resident ' s quarterly MDS (Minimum Data Set) assessment, dated 9/2/16, revealed the resident was cognitively intact. Review of the resident ' s care plan, last revised on 9/15/16, revealed the facility had identified the resident had a diagnosis of depression and staff were directed on the care plan to administer her medication as ordered to treat the depression. Review of the physician orders revealed an order was written by the NP on 8/31/16 to place the resident on 37.5 mg of the antidepressant Wellbutrin daily for five days, then to give Wellbutrin XL (extended release) 75 mg daily. Continued review of the medical record revealed a new telephone order for Wellbutrin dated 09/13/16. The order was for Wellbutrin SR (sustained release)75 mg by mouth daily and to discontinue the Wellbutrin 75 mg XL. Another telephone order dated 9/14/16 was present for Wellbutrin 75 mg SR by mouth twice per day. A telephone order dated 9/15/16 was present for a regular tablet of Wellbutrin 75 mg to be	F 281	F - 281 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. Interventions for affected resident: Resident #24 Wellbutrin was re-clarified last on 9/22/16 to 150mg XL tablet along with 75mg tablet to equal 225mg daily. New order for Wellbutrin was received from pharmacy on 9/22/16 and initiated on 9/22/16. Resident #24 is currently not on Xyzal. Order was discontinued as of 9/27/16. Interventions for residents identified as having the potential to be affected: A Medication Administration Record (MAR) to Medication Cart audit will be performed by Omnicare Pharmacy Consultants on 09/29/16 and 09/30/16 to ensure current resident medications as ordered by the Physician are available and on the medication cart readily available for administration. Any	

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F 281	Continued From page 5 administered twice per day. On 9/18/16 at 11:45 AM the September 2016 MAR (medication administration record) was reviewed with Nurse # 1. There were three transcribed Wellbutrin orders on the MAR as follows: 1) Wellbutrin 37.5 mg by mouth daily, ordered on 8/31/16, and documented on the MAR as administered at 9 AM on 9/1/16, 9/2/16, 9/3/16, 9/4/16 and 9/5/16. 2) Wellbutrin XL 75 mg by mouth daily, ordered on 8/31/16, to begin on 9/6/16 after the first five doses of Wellbutrin 37.5 mg were completed. This order was marked as discontinued on 9/13/16. 3) Wellbutrin SR 75 mg daily, ordered 9/13/16 and appeared as an active order on the MAR. The September 2016 MAR did not contain the last current Wellbutrin order dated 9/15/16 for a regular tablet of Wellbutrin 75 mg to be administered twice per day. Nurse # 1 went to the medication cart at 11:45 AM on 9/18/16, and took out the Wellbutrin medication card for Resident # 24. The medication was packaged in a bubble pack medication card which had originally had 30 doses. The medication card was labeled as 75 mg Wellbutrin. The card also contained the pharmacy prescription date of 9/15/16 which corresponded to the last order. Observation of the card with Nurse # 1 revealed there were two doses which had been removed from the 30 doses sent by the pharmacy. The nurse confirmed the two regular doses of Wellbutrin were given by her on 9/17/16 and 9/18/16 and she had signed that she administered the doses by the Wellbutrin 75 mg SR order located on the MAR.	F 281	medications not available will be promptly reordered and delivery will be confirmed by the Unit Manager or Director of Nursing. A Medication Management Review (MMR) will be performed by the facility Consultant Pharmacist on all current facility residents by 09/30/16. Any irregularities will be addressed as appropriate. Systemic Change: By 10/18/2016, the facility Staff Development Coordinator and Omnicare Consultant Pharmacist will re-educate all Licensed Nurses on appropriate transcription of physician orders and 24 hour chart check process, order/reorder process for medications that are unavailable, pharmacy delivery schedule/stat medications, and fax communication between facility/pharmacy with prompt follow-up. Licensed Nurses will check the fax machine for any pharmacy fax communications regarding medication order clarification at the beginning and end of their scheduled shift. These fax communications will be promptly acted upon. If medications are unavailable, the nurse will attempt to acquire medication Stat from pharmacy. If unsuccessful, will call the physician for alternate orders. Nursing Management will complete a random audit of (10) resident Medication Administration Record (MAR) to ensure ordered medications are readily available	

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F 281	Continued From page 6 Review of the pharmacy ' s " prescription history for 8/17/16 through 9/17/16 " for Resident # 24 revealed the history contained a list of each prescription medication date and the number of pills the pharmacy filled. According to the pharmacy prescription history, the pharmacy filled five half tablets of Bupropion (the generic form of Wellbutrin) 75 mg for an order on 8/31/16. The pharmacy filled five half tablets of Wellbutrin 75 mg again on 9/9/16. The pharmacy filled 30 doses of Wellbutrin 75 mg on 9/15/16. No other Wellbutrin was noted to have been filled by the pharmacy for Resident # 24. The September 2016 MAR and the prescription history indicated the resident did not receive any Wellbutrin on the following days: 9/6/16; 9/7/16; 9/8/16; and 9/9/16. There was a line drawn through these dates. On 9/10/16 and 9/11/16, there was documentation the resident received Wellbutrin 75 mg XL at 9 AM. According to the pharmacy prescription history there was no evidence that 75 mg XL had been filled in order that an XL dose be given on the dates of 9/10/16 and 9/11/16. The MAR indicated that the resident did not receive Wellbutrin on the following dates: 9/12/16; 9/13/16; 9/14/16; 9/15/16; and 9/16/16. On these dates there was either a nurse ' s circled initials indicating it was not given or the MAR was blank where it should have had a nurse ' s initials. The only explanation on the MAR was on 9/12/16 when Nurse # 1 noted on the back of the MAR that she had called the pharmacy and they did not have 75 mg of XL and noted the physician was also notified. On the days of 9/17/16 and 9/18/16 there was documentation the resident received Wellbutrin 75 mg SR at 9 AM on the MAR. On the pharmacy ' s prescription history there was no evidence that Wellbutrin 75 mg SR had been filled in order that a SR dose be	F 281	in the medication cart for administration. This audit will be performed weekly for three (3) months. A 24 hour chart check audit will be performed on (10) residents daily for three (3) months by the Unit Manager, Assistant Director of Nursing or Director of Nursing to ensure accurate transcription of physician orders and confirm completion of the facility 24 hour chart check protocol by the Licensed Nurse. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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given on 9/17/16 and 9/18/16. Interviews were conducted regarding this and noted below.
The ADON (assistant director of nursing) was interviewed on 9/18/16 at 2:45 PM regarding the errors and omissions in the resident ' s Wellbutrin. This interview revealed that prior to 9/18/16 the ADON did not know there had been errors. The ADON stated Nurse # 2 was assigned to care for the resident on 9/6/16; Nurse # 1 was assigned to care for the resident on 9/7/16 and 9/8/16; and Nurse # 2 was assigned to care for the resident on 9/9/16. The ADON stated the Wellbutrin was not given on these days. The ADON stated based on her investigation during the survey, Nurse # 2 did place a call to attempt to obtain a clarification order on 9/6/16 but one was never received and Nurse # 2 was off work for the next two days and clarification was also not obtained by other nurses on duty for the resident. According to the ADON, Nurse # 2 returned to work on 9/9/16 and spoke to the pharmacy again. On the evening of 9/9/16 another supply of Wellbutrin was sent to the facility although clarification had never been received from the physician. According to the ADON ' s investigation, Nurse # 2 then used the newly dispensed medication on 9/10/16 and 9/11/16 to administer a Wellbutrin dosage of 75 mg. The ADON stated the pharmacy had sent five half tablets of Wellbutrin 75 mg. The ADON stated Nurse # 2 administered two half tablets of a regular 75 mg Wellbutrin tablet and then signed on the MAR that she gave Wellbutrin 75 mg Sustained Release. The ADON stated Nurse # 2 did this although the order still needed clarifying. The ADON stated that on 9/12/16 Nurse # 1 was on duty and faxed the physician that clarification was needed and none was obtained that day. Therefore the ADON stated the resident did not

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receive Wellbutrin on 9/12/16. According to the ADON the clarification was obtained on 9/13/16 and the order was for Wellbutrin SR 75 mg one daily and to discontinue the Wellbutrin XL. The ADON stated the resident did not receive any Wellbutrin on 9/13/16. The ADON stated no medication was received from the pharmacy on the night of 9/13/16. Nurse # 2 obtained a clarification from the NP on 9/14/16 for Wellbutrin 75 mg SR twice per day. The ADON stated no Wellbutrin was sent by the pharmacy on 9/14/16 and the resident did not receive any Wellbutrin on 9/14/16. The ADON stated Nurse # 2 worked on 9/15/16 again and received the Wellbutrin order for 75 mg of a regular tablet to be administered twice per day. The ADON stated Nurse # 2 never transcribed the 9/15/16 order to the MAR after receiving the order and the resident did not receive any Wellbutrin on 9/15/16. The ADON stated Nurse # 1 was on duty on 9/16/16 and looked for the medication on 9/16/16 and could not find it so it was not administered on 9/16/16. The ADON stated the Nurse would have missed the evening dose of 9/16/16 even if the medication had been located because it had not been transcribed to the MAR as a BID (twice a day) med. The ADON stated when Nurse # 1 signed she gave Wellbutrin 75 mg SR at 9 AM on 9/17/16 that she really gave a regular dose of Wellbutrin 75 mg. The ADON stated the resident missed her evening dose of Wellbutrin 75 mg on 9/17/16 because the transcription error had still gone undetected. The ADON stated when Nurse # 1 signed she gave Wellbutrin 75 mg SR at 9 AM on 9/18/16 she really had given a regular tablet of Wellbutrin 75 mg.

Nurse # 1 was interviewed on 9/18/16 at 3:40 PM. During the interview with Nurse # 1 it was confirmed with her that the ADON had spoken to

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her on 9/18/16 in order to provide the details of the errors noted above. During the interview, Nurse # 1 stated she had called and talked to the pharmacy and asked in what dosage the Wellbutrin was supplied before she contacted the physician to obtain the 9/13/16 order.
Nurse # 2 was interviewed on 9/18/16 at 3:25 PM. During the interview with Nurse # 2 it was confirmed with her that the ADON had spoken to her on 9/18/16 in order to provide the details of the errors noted above. During the interview with Nurse # 2, the nurse indicated it had not been made clear to her the available manufacturer ' s dosages as she was trying to seek clarification of the order.
An interview conducted with the resident on 9/18/16 at 4:20 PM revealed she did not recognize her medications and relied on the nurses to administer them correctly.
A facility managerial pharmacist was interviewed on 9/19/16 at 9:15 AM and 10:40 AM via phone. According to the managerial pharmacist ' s interview the lowest dosage of Wellbutrin in either a XL (extended 24 hour dose form) or a SR (sustained release dose form) is 150 milligrams. The managerial pharmacist stated the manufacturer did not make Wellbutrin in a 75 mg SR form or a XL form and that it was contraindicated to cut a SR or XL 150 mg tablet in half in order to try to fill a lower dosage. The managerial pharmacist stated the XL Wellbutrin was typically prescribed once a day and the SR Wellbutrin was typically prescribed twice per day. The managerial pharmacist confirmed the pharmacy received the original 8/31/16 order (Wellbutrin 37.5 for five days and then 75 mg XL thereafter). The managerial pharmacist stated the pharmacy filled the initial five days of 37.5 mg and notified the facility by fax that the facility would

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need to seek physician clarification because the lowest available dosage of XL Wellbutrin was 150 mg and it could not be split. The managerial pharmacist stated the facility was notified the pharmacy could not send the rest of the medication until the order was clarified. The pharmacist stated this fax was sent to the facility on 8/31/16 when they received the original order and that the resident could not have received any Wellbutrin on 9/6/16, 9/7/16, 9/8/16, and 9/9/16 because none were supplied to the facility. According to the managerial pharmacist the pharmacy sent five doses of Wellbutrin 37.5 mg again to the facility on 9/9/16. Interview with the managerial pharmacist revealed there was no order for the 37.5 mg to be sent again to the facility on that date, but that their records showed a facility nurse called on 9/9/16 asking for the medication. The managerial pharmacist stated the pharmacist on duty looked and saw that the 8/31/16 original order was still pending in their system because it needed clarification and thought none of the Wellbutrin had ever been dispensed to the facility. Therefore the managerial pharmacist stated the pharmacy made an error on 9/9/16 when they dispensed more medication to the facility without an order. During the interview with the managerial pharmacist, the pharmacist verified that they did receive the 9/13/16 order but faxed the facility on 9/13/16 at 7:10 PM that they could also not fill this order because Wellbutrin SR was not manufactured in a 75 mg. The managerial pharmacist stated no medication was sent that day and the facility was notified by fax to clarify the order. The managerial pharmacist stated the pharmacy received the 9/14/16 order and faxed the facility on 9/14/16 at 5:50 PM again that they could not fill the order because Wellbutrin SR was

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not supplied in a dosage of 75 mg. The managerial pharmacist stated the 9/15/16 order was received by them at 5:32 PM on 9/15/16. The managerial pharmacist stated therefore the medication was not dispensed to the facility until the evening of 9/16/16. The managerial pharmacist stated their " cut off " time for new orders is 5 PM, but the nurses could have called and the Wellbutrin would have been sent on 9/15/16. The managerial pharmacist stated the Wellbutrin was sent on the evening of 9/16/16.
The ADON was interviewed again on 9/19/16 at 10:50 AM regarding how the nurses were to communicate to assure follow up about needed medications. The ADON stated pharmacy faxes were received for all the residents in the second floor supervisor ' s office and the nurses were responsible for checking the faxes. The ADON stated sometimes a supervisor would also check the faxes and deliver them to the nurses who worked on the floors. The ADON stated if a medication needed clarifying then the nurses were to pass this information along in their report during shift change so that the next nurse would know to follow up and resolve any issues with medications.

1b. Record review revealed Resident # 24 was initially admitted to the facility on 6/9/15. The resident was hospitalized in June 2016 and readmitted to the facility on 7/1/16. The resident had multiple diagnoses. These included diagnoses of chronic obstructive pulmonary disease and history of pneumonia.
Review of the resident ' s record revealed she had a current order for the antihistamine Xyzal 5 mg to be given daily at bedtime which was ordered upon her readmission date of 7/1/16. The Xyzal medication was scheduled on the resident ' s MAR (Medication administration

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record) to be given at 9 PM.
Review of the resident ' s August 2016 MAR revealed the resident did not receive the Xyzal from 8/24/16 through 8/31/16. Review of the September 2016 MAR revealed the resident did not receive the Xyzal from 9/1/16 to 9/17/16. This was a period of 25 consecutive days. All of the nurses ' initials were circled which indicated the Xyzal was not administered. There was no explanation on the MAR or in the nursing notes other than one brief notation. This notation was on the front of the MAR by the nurse ' s circled initials on the date of 9/1/16. The notation read, " called Pharm (pharmacy). " There was no further explanation.
Interview with the ADON on 9/18/16 at 3:45 PM revealed she had not been aware of the omitted doses and had verified that day (9/18/16) there was no Xyzal in the resident ' s supply of medications to be given. The ADON also did not know why the medication was not on hand. The ADON also confirmed there was no documentation she could find in the resident ' s record regarding the omitted doses of Xyzal. The ADON stated this medication was not a medication stored in their emergency supply of medications and therefore the nurses had not been administering it.
On 9/19/16 at 9:15 AM and 10:40 AM a managerial pharmacist was interviewed. The pharmacist stated their records showed the last time a refill was requested from the facility was on 8/10/15. The pharmacist stated 15 Xyzal tablets were sent on 8/11/16 to the facility. The pharmacist stated that the next refill should have been due on 8/26/16, but they did not receive a reorder request from the facility and therefore no more Xyzal was dispensed. Therefore the pharmacist also validated the Xyzal would not

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F 281	Continued From page 13 have been given by the nurses because they would have run out of their supply following 8/26/16. The pharmacist further stated their records showed the Xyzal should still have been an active medication but it had been discontinued in error in their pharmacy tracking system on 9/7/16. The pharmacist stated although it had been discontinued by the pharmacy, the facility should still have the medication as an active medication and she could not find documentation in the pharmacy system where the nurses had called. Interview with the ADON on 9/19/16 at 2:39 PM revealed two of the nurses who were responsible for the administration of the bedtime doses of Xyzal were Nurse # 3 and Nurse # 4. The ADON stated she had been able to talk to Nurse # 3 after it had been brought to her attention by the surveyor and Nurse # 3 reported she had called and faxed the pharmacy numerous times but the medication was never sent. Interview with the ADON on 9/20/16 at 11:32 AM revealed she had attempted to contact Nurse # 4 also but was not able yet to verify what follow up Nurse # 4 had done in relation to the omitted Xyzal. The ADON stated if the nurses had been having problems with the pharmacy delivering medications they should have documented what actions they were taking to obtain the medication, spoken to a supervisor about the issue, and if the issue remained unresolved then the nurses should have talked to an administrative nurse.	F 281		
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	F 425		10/18/16

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F 425	Continued From page 14 §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 record review and staff interviews the facility failed to assure accurate pharmacy dispensing of medications for one (Resident # 24) out of five sampled residents who were reviewed for medications. The findings included: 1a. Record review revealed Resident # 24 was initially admitted to the facility on 6/9/15. The resident had multiple diagnoses. These included diagnoses of chronic obstructive pulmonary disease, history of pneumonia, depression, and anxiety. Review of the record revealed an order was written by the NP on 8/31/16 to place the resident on the antidepressant Wellbutrin. This original 8/31/16 order was for 37.5 mg (milligrams) of Wellbutrin daily for five days and then to give Wellbutrin XL (extended release) 75 mg daily. Review of pharmacy records revealed the	F 425	F - 425 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. Interventions for affected resident:	

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F 425	Continued From page 15 following. On 8/31/16 the pharmacy dispensed five half tablets of Wellbutrin 75 mg to the facility. No more Wellbutrin was dispensed until 9/9/16 on which date the pharmacy again dispensed five half tablets of Wellbutrin 75 mg to the facility. A facility managerial pharmacist was interviewed on 9/19/16 at 9:15 AM and 10:40 AM via phone. According to the managerial pharmacist ' s interview, the lowest dosage of Wellbutrin in either a XL (extended 24 hour dose form) or a SR (sustained release dose form) is 150 milligrams. The managerial pharmacist stated the manufacturer did not make Wellbutrin in a 75 mg SR form or a XL form and that it was contraindicated to cut a SR or XL 150 mg tablet in half in order to try to fill a lower dosage. The managerial pharmacist confirmed the pharmacy received the original 8/31/16 order (Wellbutrin 37.5 for five days and then 75 mg XL thereafter). The managerial pharmacist stated the pharmacy filled the initial five days of 37.5 mg and notified the facility by fax that the facility would need to seek physician clarification because the lowest available dosage of XL Wellbutrin was 150 mg and it could not be split. The managerial pharmacist stated the facility was notified the pharmacy could not send the rest of the medication until the order was clarified. The pharmacist stated this fax was sent to the facility on 8/31/16 when they received the original order. Interview with the managerial pharmacist revealed the pharmacy did not receive a Wellbutrin order they could fill and dispense until the date of 9/15/16 when an order was obtained for a regular tablet of Wellbutrin 75 mg to be administered twice per day. It was also confirmed with the managerial pharmacist that prior to the date when the order was fully clarified (9/15/16), the pharmacy did dispense more Wellbutrin to the	F 425	Resident #24 Wellbutrin was re-clarified last on 9/22/16 to 150mg XL tablet along with 75mg tablet to equal 225mg daily. New order for Wellbutrin was received from pharmacy on 9/22/16 and initiated on 9/22/16. Resident #24 is currently not on Xyzal. Order was discontinued as of 9/27/16. Interventions for residents identified as having the potential to be affected: A Medication Administration Record (MAR) to Medication Cart audit will be performed by Omnicare Pharmacy Consultants on 09/29/16 and 09/30/16 to ensure current resident medications as ordered by the Physician are available and on the medication cart readily available for administration. Any medications not available will be promptly reordered and delivery will be confirmed by the Unit Manager or Director of Nursing. A Medication Management Review (MMR) will be performed by the facility Consultant Pharmacist on all current facility residents by 09/30/16. Any irregularities will be addressed as appropriate. Systemic Change: By 10/18/2016, the facility Staff Development Coordinator and Omnicare Consultant Pharmacist will re-educate all Licensed Nurses on appropriate transcription of physician orders and 24	

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F 425	Continued From page 16 facility without an order to do so. According to the managerial pharmacist and the pharmacy dispensing records, the pharmacy sent five doses of Wellbutrin 37.5 mg again to the facility on 9/9/16. Interview with the managerial pharmacist revealed there was no order for the 37.5 mg to be sent again to the facility on that date, but that their records showed a facility nurse called on 9/9/16 asking for the medication. The managerial pharmacist stated the pharmacist on duty looked and saw that the 8/31/16 original order was still pending in their system because it needed clarification and thought none of the Wellbutrin had ever been dispensed to the facility. Therefore the managerial pharmacist confirmed the pharmacy made an error on 9/9/16 when they dispensed more medication to the facility without an order. 1b. Record review revealed Resident # 24 was initially admitted to the facility on 6/9/15. The resident was hospitalized in June 2016 and readmitted to the facility on 7/1/16. The resident had multiple diagnoses. These included diagnoses of chronic obstructive pulmonary disease and history of pneumonia. Review of the resident ' s record revealed she had a current order for the antihistamine Xyzal 5 mg to be given daily at bedtime which was ordered upon her readmission date of 7/1/16. This medication was scheduled on the resident ' s MAR (Medication administration record) to be given at 9 PM. Review of the resident ' s August and September MARs revealed from 8/24/16 through 9/17/16, which was a period of 25 days, all of the nurses had documented they had not given the Xyzal. All of the nurses ' initials were circled which indicated the drug was not administered. There was no explanation on the MAR or in the nursing	F 425	hour chart check process, order/reorder process for medications that are unavailable, pharmacy delivery schedule/stat medications, fax communication between facility/pharmacy with prompt follow-up. Licensed Nurses will check the fax machine for any pharmacy fax communications regarding medication order clarification at the beginning and end of their scheduled shift. These fax communications will be promptly acted upon. If medications are unavailable, the nurse will attempt to acquire medication Stat from pharmacy. If unsuccessful, will call the physician for alternate orders. Nursing Management will complete a random audit of (10) resident Medication Administration Record (MAR) to ensure ordered medications are readily available in the medication cart for administration. This audit will be performed weekly for three (3) months. A 24 hour chart check audit will be performed on (10) residents daily for three (3) months by the Unit Manager, Assistant Director of Nursing or Director of Nursing to ensure accurate transcription of physician orders and confirm completion of the facility 24 hour chart check protocol by the Licensed Nurse. Pharmacy Manager will provide an in-service to pharmacy staff related to correctly processing orders to avoid inadvertently discontinuing active orders and ensuring medications have physician	

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F 425	Continued From page 17 notes other than one brief notation. This notation was on the front of the MAR by the nurse ' s circled initials on the date of 9/1/16. The notation read, " called Pharm. " There was no further explanation. Interview with the ADON on 9/18/16 at 3:45 PM revealed she had not been aware of the omitted doses and had verified that day (9/18/16) there was no Xyzal in the resident ' s supply of medications to be given. The ADON also did not know why the medication was not on hand. The ADON also confirmed there was no documentation she could find in the resident ' s record regarding the omitted doses of Xyzal. The ADON stated this medication was not a medication stored in their emergency supply of medications and therefore the nurses had not been administering it. On 9/19/16 at 9:15 AM and 10:40 AM a managerial pharmacist was interviewed. The pharmacist stated their records showed the last time a refill was requested from the facility was on 8/10/15. The pharmacist stated 15 Xyzal tablets were sent on 8/11/16 to the facility. The pharmacist stated that the next refill should have been due on 8/26/16, but they did not receive a reorder request from the facility and therefore no more Xyzal was dispensed. Therefore the pharmacist also validated the Xyzal would not have been given by the nurses because they would have run out of their supply following 8/26/16. The pharmacist further stated their records showed the Xyzal should still be an active medication but it had been discontinued in error in their pharmacy tracking system on 9/7/16. The pharmacist stated although it had been discontinued by the pharmacy, the facility should still have the medication as an active medication and she could not find documentation in the	F 425	orders prior to dispensing. This in-service will be completed by 10/18/16. Additionally, the pharmacy has developed a quality assurance plan and will audit to ensure compliance. Audit findings will be provided to the facility Administrator and reviewed by the facility Quality Assurance and Performance Improvement committee monthly for three (3) months. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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pharmacy system where the nurses had called or the pharmacy had detected the error.
Interview with the ADON on 9/19/16 at 2:39 PM revealed two of the nurses who were responsible for the administration of the bedtime doses of Xyzal were Nurse # 3 and Nurse # 4. The ADON stated she had been able to talk to Nurse # 3 after it had been brought to her attention by the surveyor and Nurse # 3 reported she had called and faxed the pharmacy numerous times but the medication was never sent. Interview with the ADON on 9/20/16 at 11:32 AM revealed she had attempted to contact Nurse # 4 also but was not able yet to verify what follow up Nurse # 4 had done in relation to the omitted Xyzal. The ADON stated if the nurses had been having problems with the pharmacy delivering medications they should have documented what actions they were taking to obtain the medication, spoken to a supervisor about the issue, and if the issue remained unresolved then the nurses should have talked to an administrative nurse.