STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345547	A. BUILDING: _____ B. WING _____	2/3/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN PLACE HEALTH AND REHAB, LLC	1 MARITHE COURT GREENSBORO, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 425	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

(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.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(1) 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 pharmacy failed to provide an ordered medication for 14 of 19 days Resident #1 resided in the facility. This is evident for 1 of 3 residents who were reviewed for medication administration. The findings included:

Resident #1 was admitted from the hospital to the facility in the evening on 1/12/17 and was discharged on 1/31/17. The resident was admitted to the facility for aftercare following joint replacement surgery.

A review of the discharge medications from the hospital included, "Copper PO (by mouth) 2 mg (milligrams) Take 1 capsule by mouth daily."

The care plan for Resident #1, dated 1/23/17, included a problem area of, "Potential for alteration in skin integrity r/t (relative to) decreased mobility and a diagnosis of protein calorie malnutrition. She has a left hip healing surgical incision." One of the interventions was to, "Provide diet/supplements as ordered."

A review of the medication administration record (MAR) included, "Copper 2 mg capsule take one capsule by mouth daily for supplement." The medication was documented as "N" or not given on January 13, 14, 15, 16, 18, 19, 23, 24, 25, and 26. The e-MAR stated on 1/13/17 8:42 AM that the facility was, "waiting for delivery from pharmacy" for the ordered Copper medication. On 1/14/17 at 7:49 AM the e-MAR stated, "Unavailable called pharmacy" as an explanation for not administering the ordered Copper medication. On 1/15/17 and 1/16/17 the explanation for not administering the Copper was stated on the e-Mar as waiting on arrival from pharmacy. On 1/18/17 the explanation on the e-MAR for not administering the Copper was, "family to bring supplement from home." On 1/18/17 the e-MAR explanation for not administering the Copper was, "supplement not available." On 1/23/17 the e-MAR documents the Copper was, "unavailable from pharmacy, will request that family provide medication." On 1/24/17, 1/25/17, and 1/26/17 it was documented the resident refused the Copper capsule.

A nursing progress note dated 1/26/17 in the chart of Resident #1 stated, "Spoke with Resident about providing her Copper 2 mg PO daily. She stated she was unaware she was responsible for providing her own meds. Admitted on January 12, 2017 with order for Copper capsules 2 mg PO QD (every day) per pharmacy. They have never been sent to the facility and will be sent this evening. Resident aware medication will be delivered this evening."

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 425	Continued From Page 1 The Director of Nursing (DON) was interviewed on 2/3/17 at 11:50 AM. She stated that the nursing staff send the list of discharge medications from the hospital and have them signed off by the facility physician. The list of discharge medications approved by the facility physician was then faxed to the facility pharmacy. The DON acknowledged the list of medications for Resident #1 was approved by a nurse practitioner. The DON stated, "One of the nurses should have called on the 13th or 14th to clarify why the order was not received. I am not sure what happened." The facility pharmacy was called on 2/3/17 at 12:00 PM. A pharmacy representative stated that pharmacy did have the Copper capsules at the pharmacy. She stated they did receive the faxed order for the medications on 1/12/17. The pharmacy representative stated that according to her records someone from the facility called on 1/26/17 to say the Copper had not arrived and the Copper capsules were sent to the facility on 1/26/17. The pharmacy representative did not know why they had not sent the Copper capsules for Resident #1 before 1/26/17. Nurse #1, who worked the 7AM to 3 PM shift on 1/13/17, was interviewed on 2/3/17 at 12:15 PM. She stated she had called the pharmacy when the Copper capsules did not arrive from the pharmacy for Resident #1. She stated she did not recall when she called but that she did call to request the medication be sent. She also stated that she filled out a pharmacy refill sheet to request the medication. The Director of Nursing was again interviewed on 2/3/17 at 12:35 PM. She stated that the Copper capsule was not available to give to Resident #1 until the pharmacy delivered it on the evening of 1/26/17.
F 514	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	Continued From Page 2

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to accurately document the administration of a medication to Resident #1 for 4 of 19 days of stay in the facility. This was evident for 1 of 3 residents whose medical records were reviewed. The findings included:

Resident #1 was admitted from the hospital to the facility in the evening on 1/12/17 and was discharged on 1/31/17. A review of the discharge medications from the hospital included, "Copper PO (by mouth) 2 mg (milligrams) Take 1 capsule by mouth daily."

A review of the medication administration record revealed, "Copper 2 mg capsule take one capsule by mouth daily for supplement." The medication was documented as "N" or not given on January 13, 14, 15, 16, 18, 19, 23, 24, 25, and 26. The medication was documented as administered on January 17, 20, 21, 22, 27-31.

A nursing progress note dated 1/26/17 in the chart of Resident #1 stated, "Spoke with Resident about providing her Copper 2 mg PO daily. She stated she was unaware she was responsible for providing her own meds. Admitted on January 12, 2017 with order for Copper capsules 2 mg PO QD (every day) per pharmacy. They have never been sent to the facility and will be sent this evening. Resident aware medication will be delivered this evening."

Nurse#1, who documented the Copper capsule as administered on January 17 and 20, was interviewed on 2/3/17 at 12:15 PM. She stated that the Copper capsule was not available on January 17 and January 20 so the documentation of administration were errors.

Nurse #2, who documented the Copper capsule as administered on January 21 and January 22, was interviewed on 2/3/17 at 12:45 PM. She stated that her documentation was correct and she did administer the Copper capsule to Resident #1 on January 21 and January 22.

The Director of Nursing was interviewed on 2/3/17 at 12:35 PM. She stated that the Copper capsule was not available to give to Resident #1 until the pharmacy delivered it on the evening of 1/26/17. She acknowledged the medication administration record documentation on January 17, 20, 21 and 22 were errors in documentation.