STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

(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 000	INITIAL COMMENTS The surveyor entered the facility on 4/9/18 to conduct a complaint survey and a revisit survey and exited on 4/9/18. Additional information was obtained on 4/10/18, 4/11/18, and 4/12/18. Therefore, the exit date was changed to 4/12/18. Tag F 690 was corrected as of 4/12/18. However, new tags were cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interviews, for one (Resident # 1) out of five sampled residents the facility failed to prevent neglect. The resident experienced pain for three hours and forty-five minutes before pain medication was given. The findings included:	F 600	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the	4/19/18

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

Electronically Signed | 04/20/2018

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F 600	Continued From page 1 1. Review of Resident # 1's closed record revealed the resident was admitted to the facility on 3/16/18 at 6:45 PM and transferred back to the hospital that same day at 10:50 PM. The resident did not return to the facility. Review of hospital records, which were located on the resident's facility record, revealed the following information. Prior to undergoing left total hip replacement surgery on 2/12/18, the resident had resided on her own and she was cognitively intact. On 3/11/18 the resident underwent a second orthopedic surgery after sustaining a fall and a periprosthetic femur fracture (the bone fractured around the components of the hip replacement.) On 3/16/18 the resident was discharged from the hospital to the facility for rehabilitation. According to the 3/16/18 hospital discharge summary the resident was to receive the following pain medications: Oxycontin 20 mg (milligrams) every twelve hours with meals (a sustained release medication) Oxycodone 5 mg immediate release 1 to 2 tablets every four to six hours as needed for pain. Review of the closed record revealed signed prescriptions had been sent from the hospital to the facility on 3/16/18 for both the Oxycontin and the Oxycodone as per the hospital discharge orders. The prescriptions were in the resident's closed record file. Review of the resident's admission facility orders revealed Oxycontin 20 mg (milligrams) twice per day with meals was verified as an order on 3/16/18. The Oxycodone Immediate Release 5	F 600	provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Process that lead to the deficiency Resident # 1 was admitted to the facility at 6:45PM and did not receive the requested pain medication until 10:30pm. The Charge Nurse failed to communicate in a timely manner with the on-call pharmacy and on call physician. We also identified a communication system failure that compounded the situation which was the turnaround time taken between the on-call pharmacy and the on-call physician service while attempting to obtain clarification orders for this resident. Process for implementing a plan of correction for specific deficiency On 4/11/2018 the Clinical Competency Coordinator / Nurse Managers began educating the Licensed Nurses regarding timeliness of medication first dose when admitted and notification to physician and pharmacy when a medication is not available in the Cubex system for timely delivery / code to Cubex. This education has been added to the new hire/rehire License Nurse orientation. The Transition	

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F 600	Continued From page 2 mg was also verified with one change made by the facility physician. The resident was to receive one to two tablets every four hours as needed instead of one to tablets every four to six hours as needed. Review of the resident's March, 2018 MAR (medication administration record) revealed the resident was not documented as receiving any pain medication. Review of nursing notes revealed Nurse # 1 documented the following information on 3/16/18 at 6:45 PM. The resident was admitted and was alert and oriented. The resident complained of left hip pain. The resident was "instructed on process of obtaining meds." The resident's medications were verified with a facility physician. Following the nursing entry of 3/16/18 at 6:45 PM, the next nursing entry was made on 3/16/18 at 10:15 PM. Nurse # 1 noted within the entry that she was on the phone with the pharmacy when the resident's family member requested to speak to her about the resident's pain medication. The nurse noted the family member stated, "someone told me your pharmacy is closed." The nurse noted she explained the process of obtaining medications after hours to the family member. Following the nursing entry of 3/16/18 at 10:15 PM, the next nursing entry was at 10:30 PM. The note read, "Meds obtained and taken to resident. At this time (family member) states she has called 911 to transport resident back to hospital." The last nursing entry was made on 3/16/18 at 10:50 PM. It read, "Resident taken to hospital via EMS (Emergency Medical Services)."	F 600	Nurse will obtain the Hospital Discharge summary. The Transition Nurse will review the physician discharge orders for accuracy and forward the orders to the facility. The charge nurse validates the orders with the physician then faxes the physician orders to pharmacy, the charge nurse will pull and administer the initial doses from the Cubex system that houses medications within the facility. When a narcotic is ordered the charge nurse notifies the pharmacy for an access code for the Cubex to obtain the narcotic. The charge nurse contacts the pharmacy for medications not available in the Cubex for the pharmacy to notify the on-call pharmacy for timely delivery of the medications. All medications ordered will be given timely unless ordered to be held by the attending physician. Monitoring to ensure effectiveness of POC The Director of Health Services or Nurse Managers/ Department Managers are utilization the Admission Medication Review form to verify the timeliness of medication administration within twenty-four hours of all new admissions for at least five days for two weeks, then 5 new admissions weekly for three weeks, then 5 new admissions monthly for three months, then 5 new admissions quarterly for the next 3 quarters. The Administrator and/or Director of Health Services will track and trend the Admission Medication Review form and present the analysis at the Quality Assurance and Performance	

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F 600	Continued From page 3 On 3/16/18 at 3 PM the facility provided a list of back-up medications they maintain in the facility. Oxycodone 5 mg immediate release was on the list. Oxycontin 10 mg was on the list. Oxycontin 20 mg was not on the list. The facility also provided a controlled drug record for Resident # 1. According to the controlled drug record, on 3/16/18 at 10:30 PM Nurse # 1 signed she gave two 10 mg Oxycontin pills (for a total of 20 mg) and one Oxycodone 5 mg immediate release pill to Resident # 1. According to the record, this was 3 hours and forty five minutes from the time the resident had complained of pain. Resident # 1 was interviewed on 4/10/18 at 12:20 PM via phone. The resident's responsible party was also present via speaker phone during the interview. The resident reported the following. Prior to her transfer to the facility she had been receiving intravenous morphine in the hospital because of her pain severity. On her 3/16/18 discharge date to the facility there was a long wait for the ambulance. The ride to the facility was a "rough ride" for her. When she arrived at the facility and was moved from the stretcher to the bed, it "was very painful." She asked for pain medication immediately and was told the pharmacy was closed. The resident stated she tried to move to position something beneath her, and the pain grew even worse and caused her to cry out. She stated her responsible party members stepped out in the hall to try to get her help during all of this. According to the resident's responsible party, who was also interviewed on 4/10/18 at 12:20 PM, the resident had last received pain medication at the hospital at 3 PM	F 600	Improvement Committee meeting. Title of person responsible for implementing the POC The Administrator and Director of Health Services are responsible for implementing the plan of correction.	

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F 600	Continued From page 4	F 600		

on 3/16/18. The responsible party repeatedly checked with the nurse and was told that they had to process orders and also that the facility had an influx of new residents. The responsible party stated the resident's pain was such that they decided to call 911 after hours of not receiving any pain medication.

Interview with the DON (Director of Nursing) on 4/9/18 at 12:35 PM revealed the following. When a resident arrives after 5 PM then the facility utilizes their back- up pharmacy. Narcotic prescriptions, which must match the orders, are sent to the pharmacy. The facility pharmacy then calls and gives authorization access to a nurse to remove the narcotics from the facility Cubex (the storage for the medications maintained at the facility).

A facility pharmacist was interviewed on 4/9/18 at 2:15 PM. The pharmacist reported the following. When a resident arrives after five PM, then nurses are to fax new orders to the regular pharmacy and call the back- up pharmacy. The back- up pharmacy can login to the regular pharmacy's records and view the new orders. The initial call, which is placed by the facility nurse, goes to an operator for their back-up pharmacy service. A pharmacist then receives notification from the operator service and calls to speak to the nurse. A back- up pharmacist gives an authorization code to nurses so they can access the narcotics from the Cubex system. The back-up pharmacist needs either a prescription that matches the orders, or they need to talk to the physician directly in order to give the authorization code to the nurse. If the narcotics are not in the Cubex then the back-up pharmacist contacts a local retail pharmacist to fill the

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F 600	Continued From page 5	F 600		

prescription. The pharmacist reviewed their records for Resident # 1 and reported the following from their pharmacy records. The first call was placed by Nurse # 1 to the operator service on 3/16/18 at 9:23 PM. According to the record, Nurse # 1 was requesting authorization for Oxycontin, Oxycodone, and another prescribed medication as soon as possible. The on call pharmacist returned the call to the facility on 3/16/18 at 9:38 PM and noted the following in the pharmacy call log. The orders were being faxed, the Oxycontin dosage did not match what was in the Cubex, and the nurse gave the pharmacist the physician's number so the pharmacist could speak to the physician directly. There was no notation about the Cxycodone 5 mg immediate release at 9:38 PM in the call record. On 3/16/18 at 9:50 PM faxed prescriptions were received by the on call pharmacy service. On 3/16/18 at 10:20 PM a verbal authorization was given by the physician to the pharmacist for the Oxycontin and Oxycodone. On 3/16/18 at 10:30 PM the pharmacist called and gave Nurse # 1 the authorization code to access the pain medications in the Cubex.

Nurse # 1 was interviewed on 4/9/18 at 3:20 PM. Nurse # 1 reported the following. When the resident arrived at the facility she had not had her evening 20 mg dose of Oxycontin and the resident was in pain. The nurse had to verify the orders with the new physician, fax them to the pharmacy, and obtain authorization to access the narcotics in order to give the pain medication. The nurse could not remember the specifics of the evening or factors which delayed her in talking to the pharmacy until 9:23 PM. According to the nurse, although she could not recall the specifics of the evening, it had not seemed to her

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F 600	Continued From page 6	F 600		

that it was as late as 9:23 PM before she called the pharmacy. The nurse reported that when she obtained authorization for the pain medication, she then took the medication to the resident at 10:30 PM. By that time, the family had already called 911 because the resident was having severe pain. She went ahead and gave the two pills of Oxycontin 10 mg (to equal the 20 mg dose) and she also gave her 5 mg of Oxycodone immediate release since the Oxycontin was sustained release and the resident needed relief. Soon after the medication administration, EMS arrived and transported the resident to the hospital.

Review of EMS records revealed the following information. EMS arrived at the facility on 3/16/18 at 10:43 PM. The EMS crew documented within their notes that the resident was found lying in her bed. They noted "pt. (patient) crying and in obvious pain." The EMS crew established intravenous access for medication, and noted they administered Toradol and Fentanyl. The resident was transferred back to the hospital. The EMS crew noted the resident's pain "was reduced during pt (patient) contact."

Interview with the facility administrator on 4/12/18 at 11:30 AM revealed he was contacted by the family after 9 PM on 3/16/18. He offered to personally go get needed medications and do anything possible within his control to expedite the resident getting pain medications. According to the administrator, the facility's pharmaceutical services should work in a way that allowed the facility to have and administer pain medications as soon as possible so that residents were not in pain.

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F 697	Continued From page 7	F 697		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interviews, for one (Resident # 1) of one sampled resident admitted to the facility in pain, the resident experienced pain for three hours and forty-five minutes before pain medication was given. The findings included: 1. Review of Resident # 1's closed record revealed the resident was admitted to the facility on 3/16/18 at 6:45 PM and transferred back to the hospital that same day at 10:50 PM. The resident did not return to the facility. Review of hospital records, which were located on the resident's facility record, revealed the following information. Prior to undergoing left total hip replacement surgery on 2/12/18, the resident had resided on her own and she was cognitively intact. On 3/11/18 the resident underwent a second orthopedic surgery after sustaining a fall and a periprosthetic femur fracture (the bone fractured around the components of the hip replacement.) On 3/16/18 the resident was discharged from the hospital to the facility for rehabilitation. According to the 3/16/18 hospital discharge summary the resident was to receive the	F 697	Process that lead to the deficiency Resident # 1 was admitted to the facility at 6:45PM and did not receive the requested pain medication until 10:30pm. The Charge Nurse failed to communicate in a timely manner with the on-call pharmacy and on call physician. We also identified a communication system failure that compounded the situation which was the turnaround time taken between the on-call pharmacy and the on-call physician service while attempting to obtain clarification orders for this resident. Process for implementing a plan of correction for specific deficiency On 4/11/2018 the Clinical Competency Coordinator / Nurse Managers began educating the Licensed Nurses regarding timeliness of medication first dose when admitted and notification to physician and pharmacy when a medication is not available in the Cubex system for timely delivery / code to Cubex. This education has also been added to the new hire/rehire License Nurse orientation. The Transition Nurse will obtain the Hospital	4/19/18

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F 697	Continued From page 8 following pain medications: Oxycontin 20 mg (milligrams) every twelve hours with meals (a sustained release medication) Oxycodone 5 mg immediate release 1 to 2 tablets every four to six hours as needed for pain. Review of the closed record revealed signed prescriptions had been sent from the hospital to the facility on 3/16/18 for both the Oxycontin and the Oxycodone as per the hospital discharge orders. The prescriptions were in the resident's closed record file. Review of the resident's admission facility orders revealed Oxycontin 20 mg (milligrams) twice per day with meals was verified as an order on 3/16/18. The Oxycodone Immediate Release 5 mg was also verified with one change made by the facility physician. The resident was to receive one to two tablets every four hours as needed instead of one to tablets every four to six hours as needed. Review of the resident's March, 2018 MAR (medication administration record) revealed the resident was not documented as receiving any pain medication. Review of nursing notes revealed Nurse # 1 documented the following information on 3/16/18 at 6:45 PM. The resident was admitted and was alert and oriented. The resident complained of left hip pain. The resident was "instructed on process of obtaining meds." The resident's medications were verified with a facility physician. Following the nursing entry of 3/16/18 at 6:45 PM, the next nursing entry was made on 3/16/18 at 10:15 PM. Nurse # 1 noted within the entry that	F 697	Discharge summary. The Transition Nurse will review the physician discharge orders for accuracy and forward the orders to the facility. The charge nurse validates the orders with the physician then faxes the physician orders to pharmacy, the charge nurse will pull and administer the initial doses from the Cubex system that houses medications within the facility. When a narcotic is ordered the charge nurse notifies the pharmacy for an access code for the cubix to obtain the narcotic. The charge nurse contacts the pharmacy for medications not available in the Cubex for the pharmacy to notify the on-call pharmacy for timely delivery of the medications. All medications ordered will be given timely unless ordered to be held by the attending physician. Monitoring to ensure effectiveness of POC The Director of Health Services or Nurse Managers/ Department Managers are utilization the Admission Medication Review form to verify the timeliness of medication administration within twenty-four hours of all new admissions for at least five days for two weeks, then 5 new admissions weekly for three weeks, then 5 new admissions monthly for three months, then 5 new admissions quarterly for the next 3 quarters. The Administrator and/or Director of Nursing will track and trend the Admission Medication Review form and present the analysis at the Quality Assurance and Performance	

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F 697	Continued From page 9 she was on the phone with the pharmacy when the resident's family member requested to speak to her about the resident's pain medication. The nurse noted the family member stated, "someone told me your pharmacy is closed." The nurse noted she explained the process of obtaining medications after hours to the family member. Following the nursing entry of 3/16/18 at 10:15 PM, the next nursing entry was at 10:30 PM. The note read, "Meds obtained and taken to resident. At this time (family member) states she has called 911 to transport resident back to hospital." The last nursing entry was made on 3/16/18 at 10:50 PM. It read, "Resident taken to hospital via EMS (Emergency Medical Services)." On 3/16/18 at 3 PM the facility provided a list of back-up medications they maintain in the facility. Oxycodone 5 mg immediate release was on the list. Oxycontin 10 mg was on the list. Oxycontin 20 mg was not on the list. The facility also provided a controlled drug record for Resident # 1. According to the controlled drug record, on 3/16/18 at 10:30 PM Nurse # 1 signed she gave two 10 mg Oxycontin pills (for a total of 20 mg) and one Oxycodone 5 mg immediate release pill to Resident # 1. According to the record, this was 3 hours and forty five minutes from the time the resident had complained of pain. Resident # 1 was interviewed on 4/10/18 at 12:20 PM via phone. The resident's responsible party was also present via speaker phone during the interview. The resident reported the following. Prior to her transfer to the facility she had been	F 697	Improvement Committee meeting. Title of person responsible for implementing the POC The Administrator and Director of Health Services are responsible for implementing the plan of correction.	

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F 697	Continued From page 10	F 697		

receiving intravenous morphine in the hospital because of her pain severity. On her 3/16/18 discharge date to the facility there was a long wait for the ambulance. The ride to the facility was a "rough ride" for her. When she arrived at the facility and was moved from the stretcher to the bed, it "was very painful." She asked for pain medication immediately and was told the pharmacy was closed. The resident stated she tried to move to position something beneath her, and the pain grew even worse and caused her to cry out. She stated her responsible party members stepped out in the hall to try to get her help during all of this. According to the resident's responsible party, who was also interviewed on 4/10/18 at 12:20 PM, the resident had last received pain medication at the hospital at 3 PM on 3/16/18. The responsible party repeatedly checked with the nurse and was told that they had to process orders and also that the facility had an influx of new residents. The responsible party stated the resident's pain was such that they decided to call 911 after hours of not receiving any pain medication.

Interview with the DON (Director of Nursing) on 4/9/18 at 12:35 PM revealed the following. When a resident arrives after 5 PM then the facility utilizes their back- up pharmacy. Narcotic prescriptions, which must match the orders, are sent to the pharmacy. The facility pharmacy then calls and gives authorization access to a nurse to remove the narcotics from the facility Cubex (the storage for the medications maintained at the facility).

A facility pharmacist was interviewed on 4/9/18 at 2:15 PM. The pharmacist reported the following. When a resident arrives after five PM, then

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(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
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nurses are to fax new orders to the regular pharmacy and call the back- up pharmacy. The back- up pharmacy can login to the regular pharmacy's records and view the new orders. The initial call, which is placed by the facility nurse, goes to an operator for their back-up pharmacy service. A pharmacist then receives notification from the operator service and calls to speak to the nurse. A back- up pharmacist gives an authorization code to nurses so they can access the narcotics from the Cubex system. The back-up pharmacist needs either a prescription that matches the orders, or they need to talk to the physician directly in order to give the authorization code to the nurse. If the narcotics are not in the Cubex then the back-up pharmacist contacts a local retail pharmacist to fill the prescription. The pharmacist reviewed their records for Resident # 1 and reported the following from their pharmacy records. The first call was placed by Nurse # 1 to the operator service on 3/16/18 at 9:23 PM. According to the record, Nurse # 1 was requesting authorization for Oxycontin, Oxycodone, and another prescribed medication as soon as possible. The on call pharmacist returned the call to the facility on 3/16/18 at 9:38 PM and noted the following in the pharmacy call log. The orders were being faxed, the Oxycontin dosage did not match what was in the Cubex, and the nurse gave the pharmacist the physician's number so the pharmacist could speak to the physician directly. There was no notation about the Cxycodone 5 mg immediate release at 9:38 PM in the call record. On 3/16/18 at 9:50 PM faxed prescriptions were received by the on call pharmacy service. On 3/16/18 at 10:20 PM a verbal authorization was given by the physician to the pharmacist for the Oxycontin and Oxycodone.

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On 3/16/18 at 10:30 PM the pharmacist called and gave Nurse # 1 the authorization code to access the pain medications in the Cubex.

Nurse # 1 was interviewed on 4/9/18 at 3:20 PM. Nurse # 1 reported the following. When the resident arrived at the facility she had not had her evening 20 mg dose of Oxycontin and the resident was in pain. The nurse had to verify the orders with the new physician, fax them to the pharmacy, and obtain authorization to access the narcotics in order to give the pain medication. The nurse could not remember the specifics of the evening or factors which delayed her in talking to the pharmacy until 9:23 PM. According to the nurse, although she could not recall the specifics of the evening, it had not seemed to her that it was as late as 9:23 PM before she called the pharmacy. The nurse reported that when she obtained authorization for the pain medication, she then took the medication to the resident at 10:30 PM. By that time, the family had already called 911 because the resident was having severe pain. She went ahead and gave the two pills of Oxycontin 10 mg (to equal the 20 mg dose) and she also gave her 5 mg of Oxycodone immediate release since the Oxycontin was sustained release and the resident needed relief. Soon after the medication administration, EMS arrived and transported the resident to the hospital.

Review of EMS records revealed the following information. EMS arrived at the facility on 3/16/18 at 10:43 PM. The EMS crew documented within their notes that the resident was found lying in her bed. They noted "pt. (patient) crying and in obvious pain." The EMS crew established intravenous access for medication, and noted

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F 697	Continued From page 13 they administered Toradol and Fentanyl. The resident was transferred back to the hospital. The EMS crew noted the resident's pain "was reduced during pt (patient) contact." Interview with the facility administrator on 4/12/18 at 11:30 AM revealed he was contacted by the family after 9 PM on 3/16/18. He offered to personally go get needed medications and do anything possible within his control to expedite the resident getting pain medications. According to the administrator, the facility's pharmaceutical services should work in a way that allowed the facility to have and administer pain medications as soon as possible so that residents were not in pain.	F 697		
F 755 SS=E	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-	F 755		4/19/18

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F 755	Continued From page 14 §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, resident interviews, and staff interviews the facility failed to assure two (Residents #2, and # 3) of three newly admitted residents received scheduled medications. The findings included: 1. Record review revealed Resident # 2 was admitted to the facility on 3/29/18 at 6 PM. The resident had diagnoses of intra-abdominal follicular lymphoma, a history of aspiration pneumonia, degenerative disc disease, chronic respiratory failure, reflex sympathetic dystrophy (a disorder of the nervous system which causes pain), and diabetes. Record review revealed the resident's brief interview for mental status score, dated 4/4/18, was 15. This indicated the resident was cognitively intact. Review of admission orders and the resident's March, 2018 MAR (medication administration record) revealed the following orders and MAR documentation.	F 755	Process that lead to the deficiency The charge nurse assigned to Resident #2 was new to the facility and did not understand the process of calling the backup pharmacy and/or the therapeutic intervention substitution protocol. For Resident #3, their charge nurse did call the pharmacy for the medication; however, the pharmacy did not send the medication as they thought the medication was coming from a different source. Compounding this situation, the nurses did not follow through to ensure medications where received from back-up pharmacy and/or that a therapeutic intervention form was obtained from the pharmacy with a substitute medication ordered/received and administered. Process for implementing a plan of correction for specific deficiency On 4/11/2018 the Clinical Competency Coordinator / Nurse Managers began	

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F 755	Continued From page 15 There was an order for Lantus Insulin 20 Units Subcutaneous every hour of sleep. The Lantus Insulin was scheduled on the MAR for 9 PM. The MAR was blank beside the 9 PM doses for 3/29/18 and 3/30/18. There was no blood sugar reading for 3/29/18 on the MAR. On 3/30/18 the resident's blood sugar readings ranged from 92 to 174. There was an order for Asacol HD 800 milligrams (a delayed release medication used for gastrointestinal problems) to be given three times per day. It was scheduled on the MAR for 9 AM, 1 PM, and 5 PM. Nurse # 2's circled initials appeared beside the 9 AM and 1 PM dose on 3/30/18. Nurse # 3's circled initials appeared beside the 4 PM dose on 3/30/18. There was an order for one inhalation of Breo Ellipta 200-25 microgram/dose (an inhaler for chronic respiratory disease) to be given every morning. It was scheduled on the MAR for 9 AM. Nurse # 2's circled initials appeared on 3/30/18 by the 9 AM dose. There was an order for Questran 4 gram powder packet to be given twice per day. It was scheduled on the MAR for 9 AM and 9 PM. Nurse # 2's circled initials appeared on 3/30/18 by the 9 AM dose. Nurse # 3's circled initials appeared by the 9 PM dose. There was an order for two sprays of Flonase 50 micrograms/actuation to be administered in each nostril every day. It was scheduled on the MAR for 9 AM. Nurse # 2's circled initials appeared on 3/30/18 by the 9 AM dose. There was an order for Omeprazole 20 mg every morning. It was scheduled on the MAR for 6 AM.	F 755	educating the Licensed Nurses regarding the timeliness of medications being given when residents are admitted, notification to physician and pharmacy when a medication is not available in the Cubex system for timely delivery from the back-up pharmacy, obtaining a Therapeutic Interchange for medications when appropriate and the process of obtaining codes for dispensing from the Cubex. This education has also been added to the new hire/rehire License Nurse orientation. The Transition Nurse will obtain the Hospital Discharge summary. The Transition Nurse will review the physician discharge orders for accuracy and forward the orders to the facility. The charge nurse validates the orders with the physician then faxes the physician orders to pharmacy, the charge nurse will pull and administer the initial doses from the Cubex system that houses medications within the facility. The charge nurse contacts the pharmacy for medications not available in the Cubex for the pharmacy to notify the on-call pharmacy for timely delivery of the medications or to provide a therapeutic intervention substitution. All medications ordered will be given timely unless ordered to be held by the attending physician. Monitoring to ensure effectiveness of POC The Director of Health Services or Nurse Managers/ Department Managers are	

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F 755	Continued From page 16 The MAR was blank on 3/30/18 at 6 AM. There was an order for Neurontin 900 mg three times per day. It was scheduled on the MAR for 6 AM, 2 PM, and 10 PM. The MAR was blank beside the dose on 3/30/18 at 6 AM. A facility pharmacist was interviewed on 4/10/18 at 9:45 AM. The pharmacist reported the following. The facility maintains some medications in a Cubex system which can be signed out to residents. When the medications are signed out then the pharmacy receives a record of this. Prior to the interview, the pharmacist had reviewed what medications had been signed out form the Cubex for Resident # 2 and what medications were filled from the pharmacy. The pharmacy initially received Resident # 2's faxed physician orders sheets on 3/29/18 at 5:44 PM. There is a cut off time at 5 PM, and the pharmacy makes one delivery per day. Therefore the pharmacist stated the nurses should have called the back- up pharmacy for medications which were not in the Cubex. The pharmacy had no record the facility contacted the back-up pharmacy. The Breo Ellipta inhaler, Questran, and Asacol are not in the facility's medication Cubex. The orders for these three medications were processed on 3/30/18, and these three medications were first delivered to the facility on 3/31/18 at 3:23 AM. Therefore, these three medications were not available when the nurses circled their initials indicating they were not given on 3/30/18. There was also no Lantus Insulin in the facility's back- up medication. The facility does have a back-up Insulin kit in the refrigerator which has Levemir Insulin. According to the pharmacist, there is an approved process to be followed between the facility and pharmacy.	F 755	utilization the Admission Medication Review form to verify the timeliness of medication administration within twenty-four hours of all new admissions for at least five days for two weeks, then 5 new admissions weekly for three weeks, then 5 new admissions monthly for three months, then 5 new admissions quarterly for the next 3 quarters. The Administrator and/or Director of Nursing will track and trend the Admission Medication Review form and present the analysis at the Quality Assurance and Performance Improvement Committee meeting. Title of person responsible for implementing the POC The Administrator and Director of Health Services are responsible for implementing the plan of correction.	

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The process allows the Levemir to be exchanged and utilized instead of the Lantus if there is a physician's approval to do so. According to the pharmacist there was no documentation this process had occurred on 3/29/18 and 3/30/18 or that the Lantus Insulin was sent to the facility earlier than 3/31/18 at 3:23 AM. Flonase and Prilosec are in the facility's Cubex. There was no documentation the nurses removed these medications for Resident # 2 when she was admitted on 3/29/18 or on 3/30/18. The first time they were sent by the pharmacy to the facility was on 3/31/18 at 3:23 AM. Neurontin is in the facility's Cubex. There was evidence there were three 900 mg doses removed at the following times: 3/29/18 at 5:51 PM; 3/30/18 at 9:25 AM; and 3/30/18 at 8:21 PM. There was no record a Neurontin dose was removed from the Cubex by the night shift nurse who was responsible for medications on 3/30/18 at 6 AM when the MAR was blank. The first time it was sent by the pharmacy was on 3/31/18 at 3:23 AM.

On 4/9/18 the facility provided a list of nurses who had cared for Resident # 2 on 3/29/18 and 3/30/18.

According to the list, Nurse # 5 had been the medication nurse for Resident # 2 on 3/29/18. Nurse # 5 was interviewed on 4/10/18 at 7:05 PM. The nurse reported the following. She was new to the facility. She was not familiar with the process that was to occur between the physician, pharmacy, and nurses which would enable the exchange of their back-up Levemir Insulin to be used for the Lantus Insulin. She did not recall giving the resident any Insulin on 3/29/18 and stated she would have signed for it if she had given it.

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The administrator updated the list of nurses on 4/11/18 at 12:14 PM. According to the list, Nurse # 4 was responsible for the resident's 6 AM medications on 3/30/18 when the Prilosec and the Neurontin were blank, and there had been no evidence they were removed from the Cubex. Nurse # 4 was interviewed on 4/11/18 at 1:06 PM. The nurse could not remember the details of the resident's medication administration. The nurse stated it was her standard to sign for medications she administered. The nurse stated she was aware she was to go to the Cubex when medications were not available. The nurse stated sometimes the Cubex system would say medications were there when they were not actually in the Cubex once it was accessed.

Nurse # 2 was interviewed on 4/11/18 at 10:17 AM. Nurse # 2 reported the following. She circled her initials for the Breo Ellipta inhaler, the Questran, and the Asacol on 3/30/18 because the medications were not available. She called the pharmacy and they were not delivered while she was there. She did not administer the Flonase on 3/30/18 because she had not been aware it was in the Cubex, and it had not been sent by the pharmacy.

Nurse # 3 was interviewed on 4/10/18 at 7:52 PM. Her circled initials for the Asacol and Questran meant she did not give the medications. She could not recall if she called the pharmacy. If she had given Insulin she would have signed for it, and she was not aware of an approved process to follow for an exchange of Levemir Insulin for Lantus.

Resident # 2 was initially interviewed on 4/9/18 at

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8:50 AM. The resident reported she had not received all of her medications when she was first admitted when they were due. On 4/11/18 at 12:32 PM the resident was interviewed via phone again. The resident verified Insulin was one of the missed medications and reported she had not gotten her Insulin for a couple of days when she was first admitted. The resident stated it took a while to get her medications.

Interview with the administrator on 4/12/18 at 11:30 AM revealed it was his expectation that residents receive scheduled medications. In regards to the Insulin, the administrator stated the pharmacy was supposed to fax the exchange information to the facility so that the nurses could then obtain approval and dosage orders from the physician for the back-up Levemir Insulin. According to the administrator, the facility had never received any exchange information from the pharmacy on 3/29/18 and 3/30/18.

2. Record review revealed Resident # 3 was last admitted to the facility on 3/23/18 at 2:30 PM. The resident had a diagnosis of hypertension.

Review of nursing notes revealed the resident's medication orders were faxed to the pharmacy on 3/23/18.

Review of physician orders revealed an order on 3/23/18 for Inderal 10 milligrams three times per day for hypertension.
Review of the resident's March 2018 MAR (medication administration record) revealed the following related to the resident's Inderal administration:
3/23/18-10 PM dose- Nurse # 6's initials were circles

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F 755	Continued From page 20 3/24/18 -6 AM dose- blank 3/24/18-2 PM dose-Nurse # 8's initials were circled 3/24/18 -10 PM dose-Nurse # 6's initials were circled 3/25/18-6 AM dose-Nurse # 9's initials were circled 3/25/18-2 PM dose-Nurse # 6's initials were circled 3/25/18-10 PM dose- Nurse # 6's initials were circled 3/26/18- 6 AM dose-Nurse # 9's initials were circled 3/26/18-2 PM dose-Nurse # 8's initials were circled 3/26/18-10 PM dose-Nurse # 6's initials were circled 3/27/18-6 AM dose-blank 3/27/18-2 PM Nurse # 10's initials were circled The back of the MAR did not have documentation related to why the Inderal was not given by the nurses. Record review revealed between the dates of 3/23/18 and 3/27/18 the highest documented systolic blood pressure was 137. The highest documented diastolic blood pressure was 87. Interview with a facility pharmacist on 4/9/18 at 2:15 PM revealed the Inderal was first filled and sent to the facility on 3/27/18, and the medication was not in the facility's Cubex medications (the medications stored at the facility). The pharmacist stated prior to 3/27/18, pharmacy records showed the resident's medications were being supplied by another source. According to the pharmacist there must have been confusion regarding this between 3/23/18 and 3/27/18. The	F 755		

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pharmacy records did not contain notations regarding what led to the confusion.

Nurse # 6 was interviewed on 4/10/18 at 11:40 AM. The nurse reported the following. On the dates she circled her initials, this indicated she had not given the Inderal because the medication was not available. On Resident # 3's readmission date of 3/23/18, it was her understanding that the facility pharmacy was to provide the resident's medications. The orders were faxed to the facility pharmacy. She did not recall the specifics to whether she had called about the Inderal during the days it was unavailable. The nurse did report that there had been times when she had a need to call the back-up pharmacy. The nurse stated the back-up service would give her a reference number and instruct her to call again if she had not heard from them in 30 minutes. The nurse stated there had been times when the pharmacy would not call within the 30 minutes, and she had to make more than one phone call to speak to a pharmacist.

Nurse # 8 was interviewed on 4/10/18 at 11:25 AM. According to the nurse her circled initials meant that the medication was not given. The nurse stated if the medication had been there, she would have given it.

According to staffing information provided on 4/9/18 at 5:17 PM by the administrator, Nurse # 7 was responsible for medications on 3/24/18 at 6 AM when the MAR was blank. Nurse # 7 was interviewed on 4/10/18 at 10:23 PM. According to Nurse # 7 it was her standard of practice to sign if she gave a medication. Although the nurse could not recall the specifics of why Resident # 3's Inderal was not signed as administered by her,

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F 755	Continued From page 22 the nurse stated there were times when nurses had to call the pharmacy several times for newly admitted residents' medications. According to staffing information provided on 4/9/18 at 5:17 PM by the administrator, Nurse # 11 and Nurse # 5 were responsible for medications on 3/27/18 at 6 AM when the MAR was blank. Interview with Nurse # 11 on 4/10/18 at 9:12 PM revealed nurses switched carts for that date, and Nurse # 9 had been giving 6 AM medications to Resident # 3 on 3/27/18. Nurse # 9 was interviewed on 4/10/18 at 10:54 PM. Nurse # 9 reported she circled her initials because the medication was not available. The nurse reported she called the pharmacy more than one time, and the medication was not delivered. Nurse # 10 was interviewed on 4/10/18 at 11:50 AM. The nurse reported the Inderal did come in while he was on duty on 3/27/18 and although the 2 PM dose was circled on 3/27/18, it was given by him when it arrived that day. Interview with the administrator on 4/12/18 at 11:30 AM revealed it was his expectation that residents would not miss scheduled medications. According to the administrator, the facility's pharmacy, in conjunction with their back-up pharmacy, was to provide medications on a 24 hour basis.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		4/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING _____ B. WING _____	C 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

(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 760	Continued From page 23 medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews the facility failed to administer Insulin as ordered for one (Resident # 2) of three sampled residents whose medications were reviewed. The findings included: Record review revealed Resident # 2 was admitted to the facility on 3/29/18 at 6 PM. The resident had a diagnosis of diabetes. Record review revealed the resident's brief interview for mental status score, dated 4/4/18, was 15. This indicated the resident was cognitively intact. Review of admission orders and the resident's March, 2018 MAR (medication administration record) revealed the following orders and MAR documentation. There was an order for Lantus Insulin 20 Units Subcutaneous every hour of sleep. The Lantus Insulin was scheduled on the MAR for 9 PM. The MAR was blank beside the 9 PM doses for 3/29/18 and 3/30/18. There was no blood sugar reading for 3/29/18 on the MAR. On 3/30/18 the resident's blood sugar readings ranged from 92 to 174. A facility pharmacist was interviewed on 4/10/18 at 9:45 AM. The pharmacist reported the following. There is no Lantus Insulin in the facility's back- up medication which is stored at the facility. The facility does have a back-up Insulin kit in the refrigerator which has Levemir	F 760	Process that lead to the deficiency The charge nurse assigned to Resident #2 was new to the facility and did not understand the process of calling the backup pharmacy and/or the therapeutic intervention substitution protocol. Compounding this situation, the nurses did not follow through to ensure medications where received from back-up pharmacy and/or that a therapeutic intervention form was obtained from the pharmacy with a substitute medication ordered/received and administered. Process for implementing a plan of correction for specific deficiency On 4/11/2018 the Clinical Competency Coordinator / Nurse Managers began educating the Licensed Nurses regarding the timeliness of medications being given when residents are admitted, notification to physician and pharmacy when a medication is not available in the Cubex system for timely delivery from the back-up pharmacy, obtaining a Therapeutic Interchange for medications when appropriate and the process of obtaining codes for dispensing from the Cubex. This education has also been added to the new hire/rehire License Nurse orientation. The Transition Nurse will obtain the Hospital Discharge summary. The Transition Nurse will review the physician discharge orders for accuracy and forward the orders to the	

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F 760	Continued From page 24 Insulin. According to the pharmacist, there is an approved process to be followed between the facility and pharmacy when a resident is admitted with orders for Lantus. The process allows the Levemir to be exchanged and utilized instead of the Lantus if there is a physician's approval to do so. According to the pharmacist there was no documentation this process had occurred on 3/29/18 and 3/30/18. The first time the resident's Lantus Insulin was sent to the facility was on 3/31/18 at 3:23 AM. Therefore it had not been available for administration when the MAR was blank for the doses due on 3/29/18 and 3/30/18. On 4/9/18 the facility provided a list of nurses who had cared for Resident # 2 on 3/29/18 and 3/30/18. According to the list, Nurse # 5 had been the medication nurse for Resident # 2 on 3/29/18. Nurse # 5 was interviewed on 4/10/18 at 7:05 PM. The nurse reported the following. She was new to the facility. She was not familiar with the process that was to occur between the physician, pharmacy, and nurses which would enable the exchange of their back-up Levemir Insulin to be used for the Lantus Insulin. She did not recall giving the resident any Insulin on 3/29/18 and stated she would have signed for it if she had given it. Nurse # 3 had cared for the resident on the evening of 3/30/18. Nurse # 3 was interviewed on 4/10/18 at 7:52 PM. According to the nurse, if she had given Insulin she would have signed for it. The nurse was not aware of an approved process to follow between the pharmacy, the physician, and the facility for an exchange of Levemir Insulin for Lantus.	F 760	facility. The charge nurse validates the orders with the physician then faxes the physician orders to pharmacy, the charge nurse will pull and administer the initial doses from the Cubex system that houses medications within the facility. The charge nurse contacts the pharmacy for medications not available in the Cubex for the pharmacy to notify the on-call pharmacy for timely delivery of the medications or to provide a therapeutic intervention substitution. All medications ordered will be given timely unless ordered to be held by the attending physician. Monitoring to ensure effectiveness of POC The Director of Health Services or Nurse Managers/ Department Managers are utilization the Admission Medication Review form to verify the timeliness of medication administration within twenty-four hours of all new admissions for at least five days for two weeks, then 5 new admissions weekly for three weeks, then 5 new admissions monthly for three months, then 5 new admissions quarterly for the next 3 quarters. The Administrator and/or Director of Nursing will track and trend the Admission Medication Review form and present the analysis at the Quality Assurance and Performance Improvement Committee meeting. Title of person responsible for implementing the POC	

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F 760	Continued From page 25 Resident # 2 was initially interviewed on 4/9/18 at 8:50 AM. The resident reported she had not received all of her medications when she was first admitted when they were due. On 4/11/18 at 12:32 PM the resident was interviewed via phone again. The resident verified Insulin was one of the missed medications and reported she had not gotten her Insulin for a couple of days when she was first admitted. The resident stated it took a while to get her medications. Interview with the administrator on 4/12/18 at 11:30 AM revealed it was his expectation that residents receive scheduled medications. In regards to the Insulin, the administrator stated the pharmacy was supposed to fax the exchange information to the facility so that the nurses could then obtain approval and dosage orders from the physician for the back-up Levemir Insulin. According to the administrator, the facility had never received any exchange information from the pharmacy on 3/29/18 and 3/30/18.	F 760	The Administrator and Director of Health Services are responsible for implementing the plan of correction.	