

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL063009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/08/2015
NAME OF PROVIDER OR SUPPLIER SAVANNAH FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 128 NORTH CARLISLE STREET SOUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 8, 2015.	C 000	MAR's was corrected Medication administration check list was created to prevent errors. A copy is also included.	10/9/15
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure staff accurately documented the administration of Pravachol on the Medication Administration Records (MAR) for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated	C 342		

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

TFTU11

If continuation sheet 1 of 3

Approved by L. Savannor Administrator 10/9/15

Approved by Sherry FSC 11/18/15

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAVANNAH FAMILY CARE

125 NORTH CARLISLE STREET
SOUTHERN PINES, NC 28387

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C 342	Continued From page 1 12/30/14 revealed: -Diagnoses of congestive heart failure, hypertension, pacemaker, anemia, renal insufficiency, coronary artery disease, hyperlipidemia, diabetes, and dementia. -A physician's order for Pravachol (used to reduce cholesterol) 20mg daily at bedtime. Review of Resident #1's August 2015 Medication Administration Record (MAR) revealed: -A computer generated entry for Pravachol 20mg to be administered one tablet at bedtime. -Documented initials by the Administrator that Pravachol 20mg was administered at bedtime from 08/01/15 to 08/31/15. Review of Resident #1's September 2015 MAR revealed: -A computer generated entry for Pravachol 20mg to be administered one tablet at bedtime. -There was no documentation that Pravachol 20mg had been administered during the month of September 2015. Review of Resident #1's October 2015 MAR revealed: -A computer generated entry for Pravachol 20mg to be administered one tablet at bedtime. -There was no documentation that Pravachol 20mg had been administered from 10/01/15 to 10/07/15. Interview with the Pharmacist at the contract pharmacy on 10/08/15 at 2:40 pm revealed: -The pharmacy dispensed medications for Resident #1 monthly, including Pravachol 20mg. -The physician renewed the order for Pravachol 20mg on 07/15/15. -The pharmacy pre-packaged the medications with instructions to give at the designated time of	C 342		

Division of Health Service Regulation

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C 342	Continued From page 2 day. -The Pravachol was packaged to be given at bedtime. Based on observation, record review and staff interviews, it was determined Resident #1 was not interviewable. Observation of medications on hand revealed: -Pravachol 20mg was available for administration in a pre-packaged pouch containing medications labeled to give at bedtime. -There was a computer-generated identification of each medication and strength included in the pre-packaged pouch. Interview with the Administrator on 10/08/15 at 4:15 pm revealed: -She administered medications to Resident #1. -Resident #1 received his Pravachol 20mg at bedtime. -She was responsible for documenting when the Pravachol was administered. -She knew she had given the Pravachol 20mg at bedtime for September and October 1-7, 2015 because it was packaged with other medications that Resident #1 received at bedtime. -She was not aware she had not documented on the September and October MAR's that she had administered the Pravachol 20mg to Resident #1. -Because the medications were packaged together, it was difficult to determine what medication was in the package. -She was responsible for ensuring administration of medications was documented accurately. -She reviewed MAR's monthly, but had not noticed the omission of the administration of the Pravachol in September and October 2015.	C 342			

