STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING: _____	11/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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 November 20, 2017, with an exit via telephone on November 21, 2017.	C 000		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record.	C 375	In Regards to 10A NCAC 13 G .1009 Pharmaceutical Care. An audit of the facilty records was conducted to insure that each record contained all of the quarterly pharmaceutical reviews Additionally, the administrator will review resident records quarterly to insure that reviews are completed and placed under the proper tab in resident's record. The facilty also confirmed with Care First Pharmacist, which is the contracted pharmacy for the facility, that reviews are scheduled and conducted on a quarterly basis for all residents in the facilty regardless of the pharmacy that a client or responsible party may choose to use. Care First will conduct pharmaceutical reviews and place one copy in the resident record and send one copy to the administrator. As a result, one record will remain in the file and one record will be available for any follow up recommendations that the pharmacist may make	11/21/17 11/21/17 and ongoing

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

TITLE: Administrator

(X6) DATE: 1/12/18

STATE FORM _____ WWVS11 _____ If continuation sheet 1 of 5

Review + accepted. AJS 1/17/18

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C 376	Continued From page 1	C 376		

This Rule is not met as evidenced by.
Based on record reviews and interviews, the facility failed to assure pharmaceutical reviews were completed at least quarterly for 1 of 3 sampled residents (Resident #3).

The findings are

A. Review of Resident #3's current FL-2 dated 09/12/17 revealed diagnoses included benign neoplasm of meninges, hypertension, type two diabetes, anemia and blindness in the left eye.

Review of Resident #3's Resident Register revealed an admission date of 10/03/16.

-Review of the previous FL-2 dated 09/21/16 revealed.
-An order for tradjenta 5 mg daily (used to treat hyperglycemia)
-An order for lisinopril 10 mg daily (used to treat hypertension).

Review of Resident #3's record revealed.
-The current pharmacy review was completed on 09/22/17 by a Registered Pharmacist (RPh).
-No documentation of any prior pharmacy reviews.
-An order to discontinue tradjenta 5 mg daily dated 11/29/16
-An order to discontinue lisinopril 10 mg daily dated 10/10/2016.

Review of Resident #3's Pharmacy Review dated 9/22/17 revealed
-The pharmacy review listed current medications tradjenta 5 mg daily, lisinopril 10 mg daily, ferrous sulfate 325 mg daily, losartan 50 mg daily.

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C 375	Continued From page 2	C 375		

Norvasc 10 mg daily metoprolol 75 mg twice a day, levetiracetam 500 mg twice daily, omeprazole 20 mg daily.
-Tradjenta 5 mg discontinued on 11/29/17and lisinopril 10 mg discontinued on 10/10/16 was not documented on the pharmacy review
-No recommendations were made for changes in the drug regimen
-The pharmacy review was signed by the contracted pharmacist.

Interview on 11/20/17 at 3:55 pm with the Supervisor-in-Charge (SIC) revealed
-"We only use the contracted pharmacy for pharmacy reviews."
-She did not know why Resident #3 only had one pharmacy review in his record.
-She thought Resident #3 had quarterly pharmacy reviews completed
-She did not know where Resident #3's other pharmacy reviews could be
-She thought the Administrator might have copies of all pharmacy reviews.

Interview on 11/20/17 at 5:30 pm with the Administrator revealed
-She only used one pharmacy for pharmacy reviews for all residents
-Resident #3 did not use the contracted pharmacy to obtain his medications
-Resident #3 used a local pharmacy for his medications his guardian had his prescriptions filled and the pharmacy delivered the medications to the facility.
-The contracted pharmacy completed pharmacy reviews for Resident #3 as a courtesy for the facility
-She thought the contracted pharmacy had completed quarterly pharmacy reviews for Resident #3.

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-She did not know why the pharmacy reviews were not in Resident #3's record.
-She did not know if there were additional copies of pharmacy reviews at the facility.
-The Co-Administrator was responsible for the facility paperwork.

Telephone interview on 11/20/17 at 4:10 pm with Resident #3's pharmacy revealed:
-They filled Resident #3's medications each month when his guardian called to request refills.
-They delivered Resident #3's medications to the facility.
-They did not provide pharmacy reviews for any clients because they were not a long-term care pharmacy.

Telephone interview on 11/21/17 at 3:30 pm with Co-Administrator revealed:
-He was responsible for maintaining facility paperwork.
-He was responsible to ensure pharmacy reviews were completed.
-He could not locate any additional pharmacy reviews for Resident #3 in the thinned record at the facility.
-He had contacted the facility's contracted pharmacy to obtain additional copies and was told they had none on file except for the pharmacy review completed on 9/22/17.
-The contracted pharmacy had several different pharmacists in the past year and he thought "one of the other pharmacists that doesn't work there anymore might have the records."

Telephone interview on 11/20/17 at 3:45 pm with the contracted pharmacy revealed:
-They completed pharmacy reviews at the facility for all the residents.
-They completed pharmacy reviews for Resident

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C 375	Continued From page 4	C 375		

#3 as a courtesy for the facility as they were not his pharmacy provider.
-The pharmacist who completed the pharmacy review on 09/22/17 was unavailable and could not be interviewed.
-There were no other pharmacy reviews on file for Resident #3.
-There were quarterly pharmacy reviews on file for other residents whom they supplied medications for at the facility.