STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PELICAN HEALTH HENDERSON LLC	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, staff, pharmacy representative, and physician interview the facility failed to acquire eye drops from the pharmacy until seven days after they were ordered by the physician for one (Resident #1) of three sampled residents reviewed for pharmacy services. Findings included: Resident #1 had a [DIAGNOSES REDACTED]. Documentation on the quarterly minimum data set assessment dated [DATE] revealed Resident #1 was coded as being cognitively intact. Documentation in the care plan for Resident #1 dated 7/7/20 revealed a focus area for impairment of visual function relative to [MEDICAL CONDITION] and insulin dependent diabetes mellitus. One of the interventions on the care plan was to administer ophthalmic medications as ordered. Resident #1 was interviewed on 7/7/20 at 11:30 AM. Resident #1 stated that he saw his eye doctor on 6/18/20 and was given a prescription for eye drops four times a day for his [MEDICAL CONDITION]. Resident #1 stated that the facility did not obtain the eye drops from the pharmacy until 6/25/20. Record review of the physician orders [REDACTED].#1 and was to be started on 6/19/20. The order was revised 6/23/20 by Nurse #2. Documentation in the June 2020 electronic Medication Administration Record [REDACTED]. Documentation revealed Resident #1 refused the eye drops on 6/19/20 at 9:00 AM and 12:00 PM but the eye drops were documented as administered at 5:00 PM and 9:00 PM. Resident #1 refused the eye drops on 6/20/20 at 9:00 AM but were documented as pharmacy for 12:00 PM, 5:00 PM, and 9:00 PM. On 6/21/20 the eye drops were documented as administered at 9:00 AM, 5:00 PM, and 9:00 PM but were documented as pharmacy at 12:00 PM. On 6/22/20 the eye drops were documented as pharmacy at 9:00 AM and 12:00 PM but documented as administered at 5:00 PM and 9:00 PM. The documentation on 6/23/20 did not reveal an explanation for the eye drops not being given at 9:00 AM or 12:00 PM but the eye drops were documented as administered at 5:00 PM. A nursing administration note dated 6/23/20 at 8:01 PM revealed the eye drops were, awaiting pharmacy delivery. Documentation on 6/24/20 did not reveal an explanation for the eye drops not being administered 9:00 AM or 12:00 PM but were noted as unavailable per pharmacy at 6:02 PM and not available at 8:53 PM. Documentation on 6/25/20 revealed Resident #1 began to receive the eye drops as ordered four times a day. Nurse #2 was interviewed on 7/7/20 at 12:30 PM. Nurse #2 revealed that the order for the eye drops for Resident #1 was not received by the pharmacy when it was first put into the EMR. Nurse #2 stated, There is a glitch in the system. Nurse #2 revealed that when Nurse #1 put the order into the EMR on 6/18/20, she did not choose a pharmacy and therefore the eye drops were never obtained from the pharmacy until 6/25/20. Nurse #1 indicated she discovered the order for the eye drops when the resident was transferred to her unit and had to try to figure out why the pharmacy was not sending the eye drops. Nurse #1 was interviewed on 7/7/20 at 2:30 PM. Nurse #1 stated that she was unaware of any issue with how the order for the eye drops for Resident #1 was put into the EMR. Nurse #1 said she had no way of following up or no way of knowing if the medication order was acknowledged by the pharmacy after being put into the EMR. Nurse #3, who documented administering the eye drops on 6/19/20 at 5:00 PM and 9:00 PM, was interviewed on 7/7/20 at 3:30 PM. Nurse #3 stated that she did not have the eye drops for Resident #1 on 6/19/20 and she did not administer them. She revealed that she called the pharmacy and she was told by the pharmacy the eye drops would be sent to the facility STAT or immediately. Nurse #3 stated the eye drops did not arrive at the facility before the end of her shift and she forgot to go back and change the documentation indicating the eye drops were not administered to Resident #1. Nurse #4, who documented administering the eye drops on 6/21/20 at 9:00 AM to Resident #1, was interviewed on 7/7/20 at 4:38 PM. Nurse #4 stated that on 6/21/20 the eye drops for Resident #1 were not in the facility and she did not administer the eye drops, so she called the pharmacy. Nurse #4 revealed the pharmacy told her the eye drops were already sent to the facility. Nurse #4 stated she called the physician for Resident #1, who put a hold on the medication until it could be obtained from the pharmacy. Nurse #4 stated she also let the Director of Nursing know of the hold order for the medication. Nurse #5, who documented administering the eye drops on 6/21/20 at 5:00 PM and 9:00 PM to Resident #1, was interviewed at 3:25 PM. Nurse #5 indicated she had made documentation errors on the EMAR for Resident #1 because the eye drops were not available in the facility on 6/21/20. Nurse #5 stated she did not recall if she wrote any documentation about the error or the lack of the availability of the eye drops. Nurse #1, who documented administering the eye drops on 6/22/20 at 5:00 PM and 9:00 PM to Resident #1, was interviewed again on 7/7/20 at 3:31 PM. Nurse #1 revealed she documented providing the eye drops on 6/22/20 in error and the eye drops were not in the facility on that day to be administered to Resident #1. Nurse #6, who documented administering the eye drops on 6/23/20 at 5:00 PM to Resident #1, was interviewed on 7/7/20 at 3:22 PM. Nurse #6 explained that she was unable to find the eye drops in the facility on 6/23/20, so she went to tell Resident #1 that the eye drops were not available but were supposed to be coming from the pharmacy. Nurse #6 revealed that she notified the day shift nurse, Nurse #2, that the eye drops had not come in from the pharmacy as expected. Nurse #6 revealed Nurse #2 could not locate the eye drops either. The pharmacy customer service representative (PCSR) was interviewed on 7/7/20 at 3:43 PM. The PCSR stated that the pharmacy records revealed the order for the eye drops for Resident #1 was received by the pharmacy on 6/18/20 and the eye drops were sent to the facility on [DATE] and signed for as received. The PCSR revealed an additional supply of the eye drops for Resident #1 was filled on 6/24/20 and signed for by the facility as received on 6/25/20. The unit manager was interviewed on 7/7/20 at 3:54 PM. The unit manager stated sometimes the pharmacy must be specified in the order depending on the medication order that was put into the EMR, otherwise the prescription might not be filled by the pharmacy. The physician for Resident #1 was interviewed on 7/7/20 at 4:44 PM. The physician recalled that he was contacted by a nurse regarding the eye drops not being available from the pharmacy and he ordered the medication to be put on hold until the pharmacy could provide the medication. The physician did not recall name of the nurse or the date that he was contacted about the eye drops for Resident #1. The Director of Nursing (DON) was interviewed on 7/7/20 at 4:54 PM. The DON revealed the physician for Resident #1 was contacted to put the eye drops on hold until the medication was received from the pharmacy. The DON stated that the pharmacy told her the eye drops were received by the facility on 6/21/20 and she had a handwritten documentation which listed the eye drops as received from the pharmacy. The DON revealed she informed the pharmacy that the eye drops were not received on 6/21/20 by the facility and they would need to send another supply. The DON revealed that every time the pharmacy doesn ' t send a medication the facility asks the physician if the medication could be put on hold until the medication can be obtained. The DON stated that sometimes, and it had only happened a few times, the medication orders are not received by the pharmacy and the facility had to call pharmacy to reorder the medication. The DON could not recall the exact date the eye drops were put on hold for Resident #1. An interview with the Administrator on 7/8/20 at 4:00 PM revealed the order to put the [MEDICATION NAME]-[MEDICATION NAME] eye drops for Resident #1 on hold was not available for review at that time and would need to be located in the facility. The Administrator confirmed there was no documentation in the electronic medical record at that time to indicate the eye drops for Resident #1 were put on hold in June 2020. An interview with the Administrator on 7/9/20 at 10:25 AM revealed the order to put the [MEDICATION NAME]-[MEDICATION NAME]

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PELICAN HEALTH HENDERSON LLC	**280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) eye drops for Resident #1 on hold was found in the facility by a medical record staff member along with paperwork that was to be filed. Documentation on the telephone order to hold the eye drops for Resident #1 was signed by Nurse # 4 on 6/20/20 and the physician on 6/27/20.