STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	R-C 11/26/2014

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GOLDEN LIVINGCENTER - HENDERSONVILLE	1510 HEBRON STREET HENDERSONVILLE, NC 28739

(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 Transmit FU/FC survey of 11/26/14. Event ID # FC7Y12.	F 000	Preparation and/ or execution of this plan of correction does not constitute admission or by agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by provisions of federal and state law.	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to accurately dispense medications as they were ordered for 5 of 8 residents whose medications were reviewed (Residents #14, #37, #86, 105 and # 146). The findings included: 1. Resident #14 was admitted to the facility on	F 425	F 425 SS-E The facility failed to accurately dispense medications as they were ordered for 5 of 8 residents whose medications were reviewed. (Residents #14, #37,#86, # 105, and # 146). 1.) On 11/25/14 Resident # 14 medication was re-dispensed for Risperdal 0.5 mg 2 x a day and potassium chloride 10 meq per day. The Director of Nursing validated the correct medication dose and time. The prescribed medications on the package label were verified as the medications in the packaging. On 11/25/14, The pharmacy Technician provided physical maintenance to the machine including fixing a broken divider in the hopper and replacing the sensor. On 11/25/14 Resident # 146 Clonidine identified in open package was removed from the medication cart for proper disposal of discontinued medication. Pharmacy notified of discontinued medication. Dir. of Nursing validated that the remaining medications in the packaging was correct. On 11/25/14 Resident #86 medication identified as Hydroxyzine was removed	12/15/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/23/14

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.

Original Signature Date: 12/15/14

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F 425	Continued From page 1 10/09/14 with diagnoses including Alzheimer's disease, chronic ischemic heart disease, delusional disorder and depressive disorder. Her admission Minimum Data Set (MDS) assessment dated 10/16/14 indicated she was cognitively impaired for daily decision making. Review of Resident #14's medical record revealed physician orders for Risperidone (a medication used to treat delusional disorders) 0.5 milligrams (mg) 1 tablet twice a day and Potassium Chloride (a medication used to treat ischemic heart disease) 10 milliequivalents (mEq) one every day. Resident #14 did not have an order for Duloxetine (a medication used to treat depression). Resident #14 did not have an order for Acetaminophen 325 mg/Oxycodone 5 mg (a narcotic pain medication). On 11/25/14 at 11:55 AM during inspection of the West Wing medication Cart #2 a package labeled with Resident #14's name was observed in the slot for her room. The package label indicated the medications were to be administered 11/25/14 in the afternoon. The label also indicated there were 2 medications in the package: 1 Potassium Chloride 10 mEq, described as an oblong, peach capsule and 1 Risperidone 0.5 mg, described as an oblong, brown tablet. A blue and white capsule was also observed in the package but there was nothing on the package label to indicate what the medication was. The blue and white capsule was identified by the pharmacist as being Duloxetine. On 11/25/14 at 12:30 PM the Director of Nursing (DON) was shown the package of Resident #14's medications that contained the extra, unidentified medication. The DON went to the automated dispensing unit (ADU) and programmed the	F 425	from the medication cart. Pharmacy was notified of medication order, Hydroxyzine 25 mg every 6 hours as needed. On 11/26/14, for resident #37, the packaging that contained only Depakote to be administered at 4 pm was packaged with medications to be administered at a different time, which were previously administered at the proper times. The pharmacy was notified of correct med times and errors were corrected and validated by Director of Nursing. On 11/25/14, Resident #105 had an open package in the medication cart containing 400 mg of Gabapentin and 100 mg of Gabapentin to be administered at 4 pm. Label included Cymbalta 60 mg. Cymbalta was removed and given previously as ordered at correct time of administration. Director of Nursing notified pharmacy of correct physician orders and times. A 100% audit was conducted by Nursing Management on 11/26/14 of physician's orders compared to dispensed and/or available medications in medication carts. Then compared to pharmacy active orders. Corrections were made as encountered to ensure correct medication, dose, and times were accurate and available for administration.	Cont. 12/15/14

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F 425	Continued From page 2 machine to dispense the Potassium Chloride 10 mEq and the Risperidone 0.5 mg that was scheduled to be administered on 11/25/14 at 4:00 PM. Visual inspection of the medication package that was dispensed from the ADU revealed it was labeled with Resident #14's name and indicated there were 2 medications in the package: 1 Potassium Chloride capsule 10 mEq, described as an oblong, peach tablet and 1 Risperidone 0.5 mg, described as an oblong, brown tablet. A round, white tablet was also observed in the package but there was nothing on the package label to indicate what the medication was. The white tablet was identified by the pharmacist as being Acetaminophen 325 mg/Oxycodone 5 mg). An interview with Nurse #1 on 11/25/14 at 2:20 PM about the packaging of residents' medication revealed there were times when medications that are scheduled to be given at different times are in the same package. She gave as an example that sometimes medications that are scheduled to be given in the afternoon are in with the package of medications that are scheduled to be given in the morning. She went on to say that she refers to the Medication Administration Record (MAR) to make sure she administers the medications at the right time. When asked how she determines which medication to give if there are more pills in the pack than the MAR indicates are due at the scheduled time. Nurse #1 stated she uses the description of the tablet on the package label and the imprinted number on the tablet to know which pill to give. She stated if she has a question or something doesn't match she calls the pharmacy. On 11/25/14 at 2:49 PM the DON was asked about the Duloxetine that was in Resident #14's medications and the Acetaminophen/Oxycodone	F 425	2.) A 100% audit of all residents was conducted by Nursing Management on 11/26/14 of all current physician's orders compared to dispensed and/or available medications in medication carts, then compared to pharmacy active orders. Corrections were made as encountered to ensure correct medication, dose, and times were accurate and available for administration. On 12/01/2014 Alixa Pharmacy Technician provided preventative Maintenance to the ADU Machine including reviewing hopper, sensor functioning, cartridges, and cleansing of all functional parts. 100% audit performed by Pharmacy Technician on 12/01/2014 of all dispensed medications completed to ensure accuracy of medications dispensed from the ADU. Alixa Pharmacist completed a 100% audit on 12/07/2014 comparing all active pharmacy orders with the Facility's physician's orders including specific medication, time to be administered, frequency, and dose to ensure accuracy with medication administration record. Pharmacy corrected all errors which were validated by the Director of Nursing and found to be accurate.	Cont.

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F 425	Continued From page 3 that dispensed when she re-ran the meds for Resident #14. The DON stated the medications shouldn't have been in with Resident #14's other medications because she didn't have an order for either of those medications. On 11/25/14 at 3:55 PM the facility's ADU was inspected with the Pharmacy Technician (PT). She stated she checked the machine on 11/24/14 and thought there was a sensor going bad in the machine so she planned to replace the sensor on 11/26/14. The PT explained that the machine had a sensor at the bottom of each canister of pills and also at the bottom of the chute. She stated all the medications for a scheduled medication time for a resident dispensed into the chute and then into a bag. She stated if the sensor detected more pills in the chute than the number that were scheduled for that medication time it triggered the machine to discard them in the return bin. The PT showed the surveyors and DON that a hopper guide, which guides the pills into the chute, was broken loose exposing an adhesive strip and 5 pills were stuck to the strip. She stated she thought the extra pills that were in with Resident #14's medications had probably been stuck to the strip and got knocked loose when other pills hit them. She stated she couldn't explain why the sensor didn't trigger the machine to discard the meds other than she thought the sensor needed replaced. An interview with the DON on 11/26/14 at 2:30 about the ADU dispensing extra tablets revealed she didn't know why it malfunctioned. When asked if she had been notified by nursing staff of any problems with extra pills being dispensed in residents' medication packets, she stated she hadn't until 11/25/14 when a nurse told her she	F 425	3.)To ensure ongoing accuracy, The Director of Nursing and/ or designee will fax a summary of all new orders within the last 24hrs. to the pharmacy each morning for system comparison. The Director of Nursing or designee will validate the receipt of the orders as evidenced by fax confirmations and pharmacist's electronic acknowledgment of orders with any changes made. Pharmacy will audit the 24hr. summary orders 5 days a week for 1 months, then 3 days a week for 1 month, then weekly for 1 month. Pharmacy will provide preventative maintenance to the ADU machine to include inspection of hopper, checking sensors, cartridge inspection, and cleansing 2 days a week x 3 months and ongoing as determined by the QA committee. 4.)The Director of Nursing and / or designee will audit compliance of new orders, discontinued orders, and order changes by way of electronic access to pharmacy's active orders. Corrections will be made at time of audit if indicated. Audit will be performed 5 times a week for 2 weeks then 3 times a week for 2 weeks, then 1 time a week for 2 weeks, then ongoing as determined by the Executive Director or designee. Results of the audit will be reported immediately to the Executive	Cont.

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F 425	Continued From page 4 had found a package of a resident's medication that contained a pill that wasn't listed on the package. She stated she thought the problem with the ADU dispensing extra medications was a problem they hadn't encountered before 11/25/14. 2. Resident #146 was admitted to the facility on 10/09/14 with diagnoses including vascular dementia, schizophrenia, hypertension and diabetes mellitus. An admission Minimum Data Set (MDS) assessment dated 10/23/14 indicated she had mild cognitive impairment. Review of Resident #146's medical record revealed a physician's order dated 10/09/14 for Clonidine (a medication used to treat hypertension) 0.1 milligram (mg) one tablet twice a day. A physician's order dated 11/04/14 decreased the dosage to Clonidine 0.1 mg one tablet every day at 4:00 PM. Resident #146 also had orders dated 10/09/14 for Carvedilol (a medication used to treat hypertension) 12.5 mg one tablet twice a day and Quetiapine (a medication used to treat schizophrenia) 25 mg one tablet twice a day. Review of the November 2014 Medication Administration Record (MAR) revealed the Clonidine 0.1 mg was scheduled for administration every day at 4:00 PM. The medication was documented as given once daily from 11/05/14 through 11/25/14. On 11/25/14 at 11:55 AM inspection of the West Wing Medication Cart #2 revealed 2 packages labeled with Resident # 146's name in the slot for her room. The label of one package indicated it was to be given 11/25/14 in the morning. Included in the list of medications on the package label	F 425	Director or designee. Audit results will be discussed in the monthly Quality Assurance Performance Improvement committee meeting x 3months, and ongoing as determined by the committee.	Cont. 12/15/14

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F 425	Continued From page 5 was: Clonidine 0.1 mg described as a round, orange tablet; Carvedilol 12.5 mg described as a round, white tablet and Quetiapine 25 mg described as a round, white tablet. The opened package contained only a round, orange tablet. The label of the second package indicated it was to be given 11/25/14 in the afternoon. Included in the list of medications on the package label was: Clonidine 0.1 mg described as a round, orange tablet; Carvedilol 12.5 mg described as a round, white tablet and Quetiapine 25 mg described as a round, white tablet. The package was unopened and contained 3 tablets that matched the description on the package. On 11/25/14 at 12:00 PM an interview with Medication Aide (MA) #1 revealed the Clonidine 0.1 mg that was still in the package labeled for administration on 11/25/14 in the morning had not been given because it wasn't listed on the electronic MAR as scheduled for administration in the morning. An interview with the Director of Nursing on 11/26/14 at 2:30 PM about the facility's system for notifying the pharmacy of changes in a resident's medication orders revealed all new orders were faxed to the pharmacy by the nurse who transcribed the orders. She stated the administrative nurses reviewed all new orders every morning in the daily meetings and checked to make sure the orders had been entered correctly on the electronic Medication Administration Record (MAR). She stated she also sends a list of new orders to the pharmacy after she has reviewed them. When asked if the facility's electronic MAR was linked to the automated dispensing unit (ADU), she stated it was not linked electronically. The DON stated	F 425		

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when the dosage of a medication was changed the electronic record automatically generated a discontinue order of the previous order, which was faxed to the pharmacy. She stated she had instructed the nurses to be sure to fax the order to discontinue the previous dose along with the new order to the pharmacy. The DON stated she requested a print out of every residents' medication orders from the pharmacy on 11/25/14 and compared the list they sent to the residents' current orders. She stated she notified the pharmacy of any discrepancies so both systems matched exactly. She stated she hadn't done an audit of the entire facility until 11/25/14 and she found more discrepancies than she expected. When asked about the continued dispensing of Clonidine twice a day after the order was decreased to once a day on 11/04/14, she stated she didn't recall that she had been notified by the nurses that they were still getting the Clonidine twice a day. The DON stated she had been told by the nurses that they were having to fax or call the pharmacy more than once to get medications discontinued or the dosages changed.

Review of orders faxed to the pharmacy on 11/05/14 revealed the order for Resident #146 to decrease the Clonidine 0.1 mg to once daily was faxed at 9:09 AM on 11/05/14. There was not an order to discontinue Clonidine 0.1 mg twice daily included in the orders that were faxed on 11/05/14.

During a telephone interview with the facility's consultant pharmacist on 11/26/14 at 4:00 PM he was asked if he was aware of any problems with the dispensing or medication administration system at the facility. The pharmacist stated most

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F 425	Continued From page 7 problems were due to the facility's electronic MAR not matching the information that was programmed into the ADU by the pharmacy. He stated the 2 computer systems were not interlinked and the main problems were with discontinued medications and medications that had a change in the dosing schedule. He stated he thought the root cause was that the facility wasn't faxing discontinued orders to the pharmacy. 3. Resident # 86 was admitted to the facility on 10/16/12 with cerebral artery occlusion, hyperlipidemia, vitamin D deficiency, anxiety, high blood pressure, diabetes and constipation. His quarterly Minimum Data Set (MDS) assessment dated 11/18/14 indicated he had no cognitive impairment. Resident #86's medical record revealed orders for Hydroxyzine (a medication used to treat itching) 25 milligrams (mg) 1 tablet every 6 hours as needed (prn) and Simvastatin (a medication used to treat high cholesterol) 20 mg 1 tablet daily at bedtime and Trazodone (a medication used to treat depression) 100 mg 1 tablet daily at bedtime. On 11/25/14 at 1:00 PM inspection of the East Wing Medication Cart #3 revealed 1 package labeled with Resident #86's name in the slot for his room. The label indicated that the medications were to be given 11/23/14 in the morning. Included in the list of medications on the package label was: Hydroxyzine 25 mg described as a round, white tablet, Simvastatin 20	F 425		

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mg described as an oblong tan tablet, and Trazodone 100 mg described as a round white tablet. The opened package contained only one round white tablet. By the description on the package the medication left in the packet was Hydroxyzine 25 mg.

An interview with Nurse #3 on 11/15/14 at 1:15 PM revealed that there were multiple medications placed into each package. There were medications in the morning package for the afternoon medication pass and there were medications in the afternoon package for the morning medication pass. She stated that the pharmacy had been notified that there was a problem with multiple times of medications placed into the same package, but nothing had been done to correct this problem. She stated she did not know why there was a prn medication in with the scheduled medications in the package for 11/23/14. She stated that in the last month there has been a problem with the automatic dispensing unit (ADU) not dispensing the correct number of medications into the packets. She stated that the ADU usually would dispense less of the medications.

An interview with the Director of Nursing (DON) on 11/25/14 at 2:00 PM revealed that she did not know why the pharmacy was placing prn medications in the same package with the scheduled medications. She also stated she did not know why the pharmacy was placing morning and afternoon medications in the same packet. The DON stated that she had requested a meeting with the pharmacy and the corporate office to correct this problem.

During a telephone interview with the facility's

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F 425	Continued From page 9 consultant pharmacist on 11/26/14 at 4:00 PM he was asked if he was aware of any problems with the dispensing, labeling or medication administration system at the facility. The pharmacist stated most problems were due to the facility's electronic MAR not matching the information that was programmed into the ADU by the pharmacy. He stated the 2 computer systems were not interlinked and the main problems were with discontinued medications and medications that had a change in dosing schedule. He stated he thought the root cause was the facility wasn't faxing discontinued orders to the pharmacy. The pharmacist stated the nurses and medication aides should be the final safety check in preventing medication administration errors if there was an error in the labeling. 4. Resident #105 was admitted to the facility on 08/22/14 with diagnoses including depression, pain, chronic kidney disease, cerebrovascular disease and hypertension. His admission Minimum Data Set (MDS) assessment dated 08/29/14 indicated that he was cognitively impaired for daily decision making. Review of Resident #105's medical record revealed a physician order dated 08/22/14 for Gabapentin (given for seizures and pain) 500 mg twice daily to be given at 8:00 AM and 4:00 PM. Resident #105 also had a physician order dated 11/15/14 for Duloxetine (given for depression and pain) 60 mg given once daily at 8:00 AM. On 11/25/14 at 2:00 PM inspection of the East Wing Medication Cart #2 revealed one package labeled with Resident #105's name in the slot for his room. The label of this package indicated it was to be given 11/25/14 in the afternoon.	F 425		

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Included in the list of medications on the package label was: Gabapentin 400 mg described as an oblong orange tablet; Gabapentin 100 mg described as an oblong white tablet and Duloxetine 60 mg described as an oblong blue/green capsule. The package was opened and the Duloxetine 60 mg capsule was removed and was given 11/25/14 at 8:00 AM, as documented on the Medication Administration Record (MAR.)

During an interview with Nurse #3 on 11/25/14 at 2:30 PM she explained that there were multiple medications placed in each package. There were medications in the morning packages that were for the afternoon medication pass and there were morning medications in the afternoon packages. She stated that the pharmacy had been notified there was a problem with multiple medications placed in the packages for multiple times to be given, but nothing had been done to fix the problem.

An interview was held with the Director of Nursing on 11/25/14 at 2:15 PM about the pharmacy placing multiple medications due at different time during the day in the same package. She stated she was aware of this and had requested a meeting with the pharmacy and the corporate office to try and correct this problem. She stated she felt that the best way to correct this problem would be to place only one medication in the package not multiple medications.

During a telephone interview with the facility's consultant pharmacist on 11/26/14 at 4:00 PM he was asked if he was aware of any problems with the dispensing, labeling or medication administration system at the facility. The

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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
F 425	Continued From page 11	F 425		

pharmacist stated most problems were due to the facility's electronic MAR not matching the information that was programmed into the automated dispensing unit (ADU) by the pharmacy. He stated the 2 computer systems were not interlinked and the main problems were with discontinued medications and medications that had a change in dosing schedule. He stated he thought the root cause was the facility wasn't faxing discontinued orders to the pharmacy. The pharmacist stated the nurses and medication aides should be the final safety check in preventing medication administration errors if there was an error in the labeling.

5. Resident #37 was admitted to the facility on 01/09/14 with diagnoses including bipolar disorder, mood disorder, schizoaffective disorder, hypercholesterolemia, anxiety, chronic pain, hypothyroidism, emphysema, hypertension and anemia. A quarterly Minimum Data Set (MDS) assessment dated 10/15/14 revealed that she had no cognitive impairment.

Review of Resident #37's medical record revealed a physician's order dated 08/05/14 for Duloxetine (given for depression and pain) 30 mg one tablet daily at 8:00 AM. A physician's order dated 01/09/14 for Gabapentin (given for seizures and pain) 600 mg one tablet three times a day at 8:00 AM, 12:00 Noon and 4:00 PM. A physician's order dated 10/27/14 for Divalproex (given for seizures) one tablet twice daily at 8:00 AM and 4:00 PM.

On 11/26/14 at 3:00 PM inspection of the East Wing Medication Cart #4 revealed one package labeled with Resident #37's name in the slot for room. The label of the package indicated that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	R-C 11/26/2014

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F 425	Continued From page 12 medications were to be given 11/26/14 in the afternoon. Included in the list of medications on the package label was: Duloxetine 30 mg described as an oblong white/blue capsule; Gabapentin 600 mg described as an oblong white tablet and Divalproex 500 mg described as an oblong pink tablet. By the description on the package in the medication cart, the pink oblong tablet left in the packet was Divalproex which was due to be given on 11/26/14 at 4:00 PM. The Gabapentin 600 mg was given on 11/26/14 at 12:00 Noon and the Duloxetine 30 mg was given on 11/26/14 at 8:00 AM, as documented on the Medication Administration Record (MAR.) Nurse #3 marked through the names of Gabapentin 600 mg and Duloxetine 30 mg with a black pen to let the next nurse know those two medications had already been given earlier in the day as they were documented on the MAR. These medications were all found in the same package to be given at different times during the day. During an interview with the Medication Aide #2 on 11/26/14 at 3:10 PM he explained why two of the three medications on the package were marked through was because the day shift nurse had given the medication earlier in the day and this was to let the next shift know which medications were left to be given. He stated that the packages contained medications to be given at different times throughout the day. When ask how he knew which medication had been given by the day shift, he stated that he would look at the color of the medications and match this color and marking on the tablet with the color and marking located on the package and match the medication with what was listed for that time to be given on the MAR.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 13 An interview with the Director of Nursing on 11/26/14 at 3:45 PM revealed she was aware that the pharmacy was packaging multiple medications due at different times in one package. She stated that due to the problems she had completed an audit on all the medications carts 11/25/14. She also stated that she had requested a meeting with the pharmacy and the corporate office to try and fix this problem. She stated that she felt that the problem could be fixed if the pharmacy would package only one medication per package instead of multiple medications in the same package. During a telephone interview with the facility's consultant pharmacist on 11/26/14 at 4:00 PM he was asked if he was aware of any problems with the dispensing, labeling or medication administration system at the facility. The pharmacist stated most problems were due to the facility's electronic MAR not matching the information that was programmed into the automated dispensing unit (ADU) by the pharmacy. He stated the 2 computer systems were not interlinked and the main problems were with discontinued medications and medications that had a change in dosing schedule. He stated he thought the root cause was the facility wasn't faxing discontinued orders to the pharmacy. The pharmacist stated the nurses and medication aides should be the final safety check in preventing medication administration errors if there was an error in the labeling.	F 425		