| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **KERR LAKE NURSING AND REHABILITATION CENTER** | **1245 PARK AVENUE HENDERSON, NC 27536** |

| (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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| F 312 SS=E | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, family interview, resident interview, staff interview and record review the facility failed to provide nail care to 5 of 6 residents (Resident #105, #61, #84, #96, and #13) reviewed for activities of daily living.<br>Findings include:<br>1) Resident #105 was admitted to the facility on 1/6/2014. The diagnoses included muscle weakness, other fatigue, and visual field deficits. The Minimum Data Set (MDS) dated 4/10/2015 revealed Resident #105 was moderately cognitively impaired. He required extensive assist from staff with personal hygiene. The plan of care dated 4/20/2015 included Resident #105 required assistance to restore maximum function of self-sufficiency for personal hygiene and an inability to focus on objects. Nail care was not excluded.<br>An interview on 6/29/2015 at 2:25 PM with Resident #105 revealed he was alert and oriented and aware of daily activities. He reported he had asked the facility several times be on the nail trimming list [fingers and toes] and the staff told him he was not on the list. Resident #105 did not know why he was not on the list. His sister had been cutting his nails. Resident #105 reported his nails needed to be cut stating " look at my nails " while holding his hands out for observation. | F 312 | Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br>Kerr Lake Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and / or any other administrative or legal proceedings.<br><br>1. Residents # 105, #61, #84, # 96 and #13 had fingernails and toe nails inspected and trimmed on 7/2/15 by the treatment nurse. Resident # 105 had | 7/30/15 |

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

Electronically Signed | 07/24/2015

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| F 312 | Continued From page 1<br>On 6/29/2015 at 2:30 PM an observation was made of Resident #105 ' s fingernails. His fingernails were long [longer than ordinary and customary] extending over the top of the fingertip pads.<br>On 07/02/2015 at 12:22 PM Nurse Assistant (NA) #1 revealed she cared for resident nails every day and the nail clippers were kept at the nurse station. She further reported it was the responsibility of facility to cut nails.<br>On 07/02/2015 at 12:39 PM the Director of Nursing (DON) revealed all staff were responsible for providing nail care to residents. NAs and nurses if they have time. The nurses had nail clippers on the medication carts and with the treatment nurse. The DON revealed a full box of nail clippers in her office desk. The DON reported the facility provided nail care for residents that were moderately cognitively impaired and supervised residents because they were not going to be able to cut their own nails. Her expectation was for staff to ask for help if they could not accomplish the task. Staff members were preferred to provide nail care over family. Residents who like long nails are generally care planned for that.<br>On 07/02/2015 at 3:10 PM NA #1 reported Resident #105 refused nail care.<br>On 07/02/2015 at 3:53 PM the DON revealed residents were placed on the podiatry nail care list [for toenails] when they had a diagnosis of Diabetes, an arterial problem, or the nail was too thick. The treatment nurse comes up with the list. If there was a nail problem that could not wait for the podiatry visit then the facility got an order to send the resident to the podiatrist office. Nurses and nurse assistance are responsible for nail care for the residents.<br>On 07/02/2015 at 3:58 PM an interview with the | F 312 | appointment scheduled with podiatrist by the scheduler and attended appointment on 7/9/15. Resident #84 had podiatry appointment scheduled for 7/31/15 by the scheduler.<br>2. 100% residents, using a facility census, were assessed by DON, ADON, MDS Nurses, Staff Facilitator, Treatment Nurse, and Patient Care Coordinators for ADL's to include fingernail and toenail care needs by 7/3/15. Resident with needs identified were addressed immediately by providing nail care by the DON, ADON, MDS Nurses, Staff Facilitator, Treatment Nurse, and Patient Care Coordinators who observed the need. Residents requiring podiatry appointments had podiatry appointments scheduled by the scheduler.<br>3. Inservices on Resident ADL care to include proper technique for fingernail and toenail care were initiated on 7/7/15 to 100% of nursing staff to include C N A #1 and C N A #2 by the Staff Facilitator. Inservices were completed to 100% of nursing staff including C N A's by 7/22/15. New hires will be educated on Resident ADL care to include fingernail and toenail care during the orientation process by the Staff Facilitator.<br>4. Residents, to include residents # 105, #61, #84, # 96 and #13, will be observed, using a resident care audit tool, by the DON, ADON, Staff Facilitator, Treatment Nurse, and Patient Care Coordinators to ensure personal grooming and care needs, to include fingernail and toenail care, are met. The DON, ADON, Staff Facilitator, Treatment Nurse, and Patient | |

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| F 312 | Continued From page 2<br>treatment nurse revealed the podiatrist visit was every three months. The treatment nurse reported that she go through the residents and look at the toe nails to decide who is put on the list.<br>On 07/02/2015 at 4:32 PM an interview with the treatment nurse revealed Resident #105 " does his own. "<br>On 07/02/2015 at 4:35 PM on interview with Resident #105 ' s sister revealed she had cut Resident #105 ' s fingernails the other day because they need it bad. She reported there use to be a male nurse assistant who trimmed his nails but he left months ago. Resident #105 ' s sister reported she would like the facility staff to maintain her brother ' s nails and his toenails were too thick for her to handle.<br>On 7/2/2015 at 4:40 PM Resident #105 reported " no CNA (nurse assistant) come in here " . Resident #105 was referring to his nails and the treatment nurse was present. " Some other nurse said I was not on the list. "<br>On 7/2/2015 at 4:40 PM an observation was made of Resident #105 ' s nails. His fingernails were still long extending over the top of the fingertip pads and his toenails were discolored yellow, long, thick and raised.<br>On 7/2/2015 at 4:40 PM the treatment nurse assessed Resident #105 ' s nails and reported she could trim his fingernails and she would need to make an appointment with the podiatrist for his toe nails.<br>On 7/2/2015 at 4:42 PM Resident #105 and his sister agreed with the treatment nurse that Resident #105 would need to see the Podiatrist for his toenails.<br>2) Resident #61 most recent admission to the facility was on 3/26/2015. The diagnoses included Trans Ischemic Attack, altered mental status, | F 312 | Care Coordinators will complete resident care observations to include residents # 105, #61, #84, # 96 and #13,at 50% per week for 4 weeks, then 25% per week for 4 weeks, then 10 % of residents per week for 3 months. Any resident needs identified will be immediately addressed by facility staff, with corrective action taken and retraining of staff as necessary upon the identification of any potential concern. The DON or Administrator will review the results of the audits as indicated by initialing each Resident Care Audit Tool weekly. Results of the Resident Care Audits will be reviewed by the Resident Care QI Committee monthly x 5 for identification of trends, actions taken, and reviewed at he Executive QI meeting quarterly to determine the need for and / or frequency of continued monitoring, recommendations for monitoring and continued compliance. | |

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| F 312 | Continued From page 3<br>nonpsychotic mental disorder following organic brain damage, cognitive deficits, hemiplegia affect due to Cardiovascular Accident. The MDS dated 5/12/2015 revealed Resident #61 was cognitively impaired and required extensive assistance from staff with personal hygiene. The plan of care dated 5/20/15 revealed Resident #61 required assistance to restore maximum function of self-sufficiency for personal hygiene characterized by the following function; shaving mouth care, daily maintaining of appearance. Nail care not on resident care guide.<br>On 6/29/2015 at 2:45 PM an observation of Resident #61 revealed his fingernails were long [longer than ordinary and customary] extending over the top of the fingertip pads.<br>On 6/29/2015 at 2:46 PM an interview with Resident #61 revealed he was alert and oriented and able to communicate. When asked who cut his fingernails he reported his sister cut his nails. When asked if the staff members offered to cut his nails he answered no. When asked if he would like his nails cut he responded yes.<br>On 07/02/2015 at 12:22 PM NA #1 revealed she cared for resident nails every day and the nail clippers were kept at the nurse station. She further reported it was the responsibility of facility to cut nails.<br>On 07/02/2015 at 12:39 PM the Director of Nursing (DON) revealed all staff were responsible for providing nail care to residents. NAs and nurses if they have time. The nurses had nail clippers on the medication carts and with the treatment nurse. The DON revealed a full box of nail clippers in her office desk. The DON reported the facility provided nail care for residents that were moderately cognitively impaired and supervised residents because they were not going to be able to cut their own nails. Her | F 312 | | |

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expectation was for staff to ask for help if they could not accomplish the task. Staff members were preferred to provide nail care over family.
07/02/2015 3:10 PM NA #1 reported resident #61 ' s sisters cut his nails.
On 07/02/2015 at 3:53 PM the DON revealed residents were placed on the podiatry nail care list [for toenails] when they had a diagnosis of Diabetes, an arterial problem, or the nail was too thick. The treatment nurse comes up with the list. If there was a nail problem that could not wait for the podiatry visit then the facility got an order to send the resident to the podiatrist office. Nurses and nurse assistance are responsible for nail care for the residents.
On 7/2/2015 at 3:40 PM an interview with Resident #61 ' s sister #1 revealed she and her sister cut Resident #61 ' s nails. She reported the facility was not doing it. His toe nails had not been cut in over 1 year. Sister #1 reported she tried but resident #61 ' s toenails were " hard and he needs to see a doctor about them. " Sister #1 did not know about a podiatrist. She further stated " His nails would not get cut if my sister and I did not do it. "
On 07/02/2015 at 4:32 PM an observation of Resident #61 ' s fingernails revealed jagged edges and his toe nails revealed on his left long exceeding ordinary and customary and his right yellow, thick, raised, multi layered long nails. The treatment nurse offered to trim Resident #61 ' s toenails and Resident #61 accepted.
On 07/02/2015 at 4:32 PM an interview with the treatment nurse revealed Resident #61 ' s sisters trim his nails. She reported she gave them finger nail and toe nail clippers.
On 7/2/2015 at 4:50 PM an interview with Resident #61 sister #2 revealed she had not observed the staff offer to cut Resident #61 ' s

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nails. She reported she keeps them trimmed but does not like to. She reported his toe nails were thick and she was uncomfortable trimming them. Sister #2 reported she would prefer the facility staff maintain resident #61 ' s nails.

3) Resident #84 was admitted to the facility on 5/14/2015. The diagnoses included psychosis, symbolic dysfunction (social impairment), anxiety, rhabdomyolysis (muscle injury). The MDS dated 5/22/2015 revealed resident #84 was moderately cognitively impaired. He required extensive assistance from staff with his personal hygiene. The plan of care dated 6/15/2015 for Resident #84 included required assistance: potential to restore or maintain maximum function of self-sufficiency for personal hygiene. Nail care was not excluded.
On 7/2/2015 at 10:12 AM an observation of Resident #84 revealed his fingernails were long [longer than ordinary and customary] extending over the top of the fingertip pads.
On 07/02/2015 at 12:22 PM NA #1 revealed she cared for resident nails every day and the nail clippers were kept at the nurse station. She further reported it was the responsibility of facility to cut nails.
On 07/02/2015 at 12:39 PM the Director of Nursing (DON) revealed all staff were responsible for providing nail care to residents. NAs and nurses if they have time. The nurses had nail clippers on the medication carts and with the treatment nurse. The DON revealed a full box of nail clippers in her office desk. The DON reported the facility provided nail care for residents that were moderately cognitively impaired and supervised residents because they were not going to be able to cut their own nails. Her expectation was for staff to ask for help if they

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could not accomplish the task. Staff members were preferred to provide nail care over family.
On 07/02/2015 at 2:49 PM an interview with Resident #84 ' s wife revealed she cut her husband ' s (resident #84) nails every few weeks. She reported no staff member had offered to do it and she was here most days.
On 7/2/2015 at 2:50 PM an observation of Resident #84 revealed his nails were jagged and long. He was alert and oriented to person and was aware of his surroundings.
On 7/2/2015 at 2:50 PM Resident #84 looked at his nails and said " look at them. " He turned to wife and said " cut them. "
On 7/2/2015 at 2:50 PM Resident #84 ' s wife responded she did not want to cut them she could barely see and to cut her own she would rather the facility cut them. Resident #84 said again "look at them."
On 07/02/2015 at 3:53 PM the DON revealed nurses and nurse assistance are responsible for nail care for the residents.
4) Resident #96 was admitted to the facility on 11/5/2014. The diagnoses included dementia and symbolic dysfunction. The MDS dated 5/6/2015 revealed resident #96 was moderately cognitively impaired. He required extensive assistance from staff with personal hygiene. The plan of care dated 4/28/2015 revealed Resident #96 required assistance: potential to restore or maintain maximum function of self-sufficiency for personal hygiene. Characterized by the following function; shaving, makeup application, mouth care, daily maintaining of appearance. Nail care not on resident care guide.
On 6/29/2015 at 4:22 PM a family interview revealed the responsible party (RP) had asked for the facility to cut his nails. He was to be placed on a list 3-4 months ago and the RP reported the

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family had not heard anymore. The RP reported she recently trim his fingernails and about 2 weeks ago she took Resident #96 to the physician (podiatrist). The RP was displeased to learn from the physician that he comes to the facility to trim nails after she had taken extra steps to provide nail care to resident #96.
On 07/02/2015 at 12:22 PM NA #1 revealed she cared for resident nails every day and the nail clippers were kept at the nurse station. She further reported it was the responsibility of facility to cut nails.
On 07/02/2015 at 12:39 PM the Director of Nursing (DON) revealed all staff were responsible for providing nail care to residents. NAs and nurses if they have time. The nurses had nail clippers on the medication carts and with the treatment nurse. The DON revealed a full box of nail clippers in her office desk. The DON reported the facility provided nail care for residents that were moderately cognitively impaired and supervised residents because they were not going to be able to cut their own nails. Her expectation was for staff to ask for help if they could not accomplish the task. Staff members were preferred to provide nail care over family.
On 07/02/2015 at 3:10 PM NA #1 reported Resident #96 ' s family cut his nails.
On 07/02/2015 at 3:53 PM the DON revealed residents were placed on the podiatry nail care list [for toenails] when they had a diagnosis of Diabetes, an arterial problem, or the nail was too thick. The treatment nurse comes up with the list. If there was a nail problem that could not wait for the podiatry visit then the facility got an order to send the resident to the podiatrist office. Nurses and nurse assistance are responsible for nail care for the residents.
On 07/02/2015 at 3:53 PM the DON revealed

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nurses and nurse assistance are responsible for nail care for the residents.

5) Resident #13 was admitted on 1/6/2014. The diagnoses included dementia. The MDS dated 6/18/2015 revealed Resident #13 was cognitively impaired and required extensive assistance from staff with personal hygiene. Resident #13 ' s Care Plan included a progressive decline in intellectual functioning characterized by: deficit in memory, judgement, decision making, and thought process related to short term memory loss. Resident #13 was at risk for unmet needs and/or compromised dignity.
On 7/1/2015 at 11:43 AM an observation of resident #13 revealed his fingernails were long [longer than ordinary and customary] extending over the top of the fingertip pads.
On 7/1/2011 at 11:50 AM an interview with Resident #13 revealed if someone offered to cut his nails he would like them cut and would not mind if the staff cut his nails. He was alert and oriented to person and location.
On 07/02/2015 at 12:50 PM NA #2 revealed she shaves Resident #13 and cut his nails. NA #2 reported he does everything else himself. " If he needs anything he lets us know. " NA #2 revealed she had not offered to cut his nails on this day.
On 7/2/2015 at 12:55 PM NA #2 reported she offered to trim Resident #13 ' s nails at this time. Resident #13 responded in a couple of days. Note Resident #13 was in his room at lunchtime visiting with a fellow resident. He was not receiving morning care at this time.
On 07/02/2015 at 12:39 PM the Director of Nursing (DON) revealed all staff were responsible for providing nail care to residents. NAs and nurses if they have time. The nurses had nail

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| F 312 | Continued From page 9<br>clippers on the medication carts and with the treatment nurse. The DON revealed a full box of nail clippers in her office desk. The DON reported the facility provided nail care for residents that were moderately cognitively impaired and supervised residents because they were not going to be able to cut their own nails. Her expectation was for staff to ask for help if they could not accomplish the task. Staff members were preferred to provide nail care over family. On 07/02/2015 at 3:53 PM the DON revealed nurses and nurse assistance are responsible for nail care for the residents. | F 312 | | |
| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff interview the facility failed to follow professional standards to administer 1 of 26 medications, Risperdal an short acting antipsychotic medication, during medication pass observation for 1 of 7 residents (Resident #84) by 1) delayed/missing a scheduled dose of administration and 2) attempted to borrow a dose from another resident.<br>Findings include:<br>Resident #84's original admission to the facility was on 8/29/2014 and the most recent admission was dated 5/14/2015. The diagnoses included Unspecified Psychosis, Symbolic Dysfunction (social impairment), and Anxiety. The Minimum Data Set (MDS) dated 5/22/2015 revealed | F 333 | Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br>Kerr Lake Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake | 7/30/15 |

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| F 333 | Continued From page 10<br>Resident #84 was moderately cognitively impaired.<br>A record review of consult psychiatric physician progress note dated 6/15/2015 included Resident #84's psychosis had been occurring with greater intensity and frequency over the last month. The physician ' s recommendation included start Risperdal 0.25mg by mouth twice a day for Psychosis.<br>Resident #84 was care planned for problematic manner in which resident acts characterized by ineffective coping: 1) Anxiety related to a diagnosis of anxiety and episodes of delusions, 2) wandering and/or at risk for unsupervised exits from facility related to cognitive impairment. Resident #84 was also care planned for the use of psychotropic medications which included Risperdal.<br>A record review of Resident #84 ' s Medication Administration Record (MAR) for July 2015 included Risperdal 0.25mg (milligrams) scheduled twice a day at 9:30 AM and 4:00 PM. The order was started on 6/15/2015.<br>On 7/2/2015 at 10:05 AM a medication pass observation with Nurse #1 for Resident #84 began.<br>On 7/2/2015 at 10:10 AM Nurse #1 verbalized Risperdal was not available for Resident #84 and her resolution was she would order the medication from the pharmacy to arrive that evening. Nurse #1 passed the remaining medications to Resident #84 and initiated a breathing treatment. No communication was communicated to Resident #84 or the responsible party in the room about the unavailable medication (Risperdal). Nurse #1 initialed the MAR and circled initials indicating the medication was not administered. Nurse #1 noted on the back of the MAR: 7/2/2015 10:00 Risperdal | F 333 | Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and / or any other administrative or legal proceedings.<br>1. Resident # 84's physician was notified of medication, Risperdal, not being available on 7/2/15 at approximately 10:15am by Nurse # 1. An order was received to obtain Risperdal from back up pharmacy and administer the medication when available from back up pharmacy. Neil Medical Pharmacy was contacted by Nurse #1 and pharmacy ordered medication from local pharmacy. At approximately 11:45am, Nurse # 1 was notified by Walgreens Pharmacy of Henderson that the medication was available. The receptionist obtained the medication from Walgreens Pharmacy of Henderson and delivered to Nurse # 1 who administered the medication to resident # 84 at approximately noon on 7/2/15.<br>2. An audit was completed by the DON, ADON, Staff Facilitator, MDS Nurses, and Patient Care Coordinators of 100% of residents, to include resident # 84, medications using a resident census on 7/3/15 to ensure all medications were available. Any unavailable medications were obtained from back up by the charge nurse and administered to resident per physician order until received from Neil Medical Pharmacy.<br>3. On 7/7/15, education was initiated to 100% of Licensed Nurses to include | |

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| | 345321 | A. BUILDING _____ B. WING _____ | C 07/02/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **KERR LAKE NURSING AND REHABILITATION CENTER** | **1245 PARK AVENUE HENDERSON, NC 27536** |

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| F 333 | Continued From page 11<br>0.25mg [Reason coded B] drug temporarily unavailable.<br>On 7/2/2015 events starting at 10:25 AM when asked what Nurse #1 ' s plan was to administer Resident #84's unavailable dose of Risperdal Nurse #1 reported her plan was to call the pharmacy to order the medication for delivery in the PM. When asked Nurse #1 did not have an answer for the significance of the medication [Risperdal] and if a dose should be missed. Nurse #1 did not verbalize she would check the emergency supply kit, call the backup pharmacy or notify the physician for the unavailable dose of Risperdal on her own. When asked if there were other options to obtain a dose Nurse #1 went to look at the facility emergency supply cart. Risperdal 0.5 mg dose was available but not scored. Nurse #1 discussed her dilemma with a staff nurse, Nurse #2 and the Nurse #2 reported she would ask the Director of Nursing (DON). The Nurse #2 returned and reported the DON said to borrow the dose from another resident and replace it when Resident #84's supply came in in the evening. Nurse #1 returned to the cart and verbalized who she thought might have the same dose of Risperdal as Resident #84. Nurse #1 was asked what she was instructed to do by the DON and she reported the DON said to borrow a medication dose from another resident and replace it when the supply came in. Nurse #1 was then asked what she learned in nursing school and she stated "not to borrow medications from other residents." Nurse #84 was asked who had the authority to decide whether the dose of medication could be missed she reported the physician.<br>On 07/02/2015 at 11:20 AM Nurse #1 reported that she called the on call physician, as suggested, and was instructed to receive a dose | F 333 | Nurse # 1 by the Staff Facilitator on appropriate procurement of medications to include reordering, obtaining medications from back up, and no borrowing of medication with inservice completion to all nurses by 7/22/15.<br>Newly hired licensed nurses will be educated on medication procurement to include reordering, obtaining medications from back up, and no borrowing of medication, during the orientation process by the Staff Facilitator.<br>4. Using a Medication Cart Audit Tool, 100 % of medication carts will be audited by the DON, ADON, Staff Facilitator, and Patient Care Coordinators to ensure all resident's medications, to include resident # 84's medications, are available. Any medications not available will immediately reported to the DON by the charge nurse and will be obtained through back up procedure. This monitoring will occur weekly for 4 weeks, then every 2 weeks for 8 weeks, then monthly for 3 months. The DON or Administrator will review and initial the audit tools weekly for 4 weeks, then every 2 weeks for 8 weeks, then monthly for 3 months.<br>A Medication Reorder tracking tool was implemented on 7/17/15 to include the resident name/ medication/ date ordered/ date received and follow up with pharmacy as needed. The Medication Reorder tracking tool will be completed by the charge nurses and reviewed by the DON, ADON, Staff Facilitator, Treatment Nurse or Patient Care Coordinator daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then | |

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| F 333 | Continued From page 12<br>of Risperdal for Resident #84 from the local back up pharmacy and administer the dose upon arrival.<br>On 07/02/2015 at 12:33 PM an interview with the DON revealed her expectation was when there were 3 or 4 days left of a medication there was a cardboard piece [medication refill tab] on the prescription box that was to be pulled by a staff member and a reorder sheet was to be faxed to pharmacy. The DON reported the reorder sheets end up in the shred box. There was no tracking system. When the nursing staff get to the last dose of medication the nurse looks for the new box and if they do not see a new box they will call the pharmacy. " It is not in our policy or practice to borrow medications from other residents. " | F 333 | monthly for 3 months to ensure medications are reordered and received timely. The DON or Administrator will review and initial the audit tools daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 3 months.<br>Results of the Medication Cart Audit Tool and Medication Reorder Tracking Tool will be reviewed by the Medication Availability QI committee monthly x 6 months for identification of trends, actions taken, and reviewed at the Executive QI meeting quarterly to determine the need for and / or frequency of continued monitoring, recommendations for monitoring and continued compliance | |