

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/07/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345369 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 09/03/2015 |
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| NAME OF PROVIDER OR SUPPLIER REX REHAB & NSG CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4420 LAKE BOONE TRAIL RALEIGH, NC 27607 | | |
| (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 | F 000 | | | |
| F 280 SS=D | <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to develop a care plan to address the use of an anticoagulation (blood thinner) medication for 2 of 5 sampled residents (Resident #14 and Resident #153) reviewed for unnecessary medications. Findings included:</p> | F 280 | <p>1. As noted, the MDS nurse provided an updated care plan for residents #14 and #153 that included anticoagulation therapy and precautions.</p> <p>2. The MDS nurses will conduct an audit for all residents on anticoagulation therapy and will ensure the anticoagulation</p> | 10/1/15 | |

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

TITLE

(X6) DATE

Electronically Signed

09/24/2015

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.

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| F 280 | <p>Continued From page 1</p> <p>1. Resident #14 was admitted to the facility on 10/11/12 with cumulative diagnoses of atrial fibrillation (an abnormal heart rhythm) and a cerebral vascular accident (stroke).</p> <p>The quarterly Minimum Data Set (MDS) dated 6/16/15 indicated Resident #14 had moderate cognitive impairment and required extensive assistive all of her activities of daily living (ADLs) except supervision while eating. The MDS assessment also indicated Resident #14 received an anticoagulant medication 7 out of 7 previous days.</p> <p>A review of Resident #14's medical record revealed on 8/26/15 orders included the following: Coumadin (anticoagulant) 9 milligrams (mg) to be given Mondays, Tuesdays, Fridays, Saturdays and Sundays and 8 mg to be given on Tuesdays and Thursdays with lab work repeat on 9/2/15.</p> <p>A review of Resident #14's care plan (initiated 9/11/12 and last revised 6/17/15) revealed no problem area related the use of an anticoagulant medication. However, Resident 14 was care planned for falls risk due impaired mobility and pain.</p> <p>In an interview on 9/2/15 at 12:20 PM, nursing assistant (NA) #1 assigned Resident #14 stated she had worked at the facility for approximately 4 months and she trained to follow the Caregiver Instructions taped to the inside of each bathroom door. NA #1 verified there was no communication on the Caregiver Instructions informing staff that Resident #14 was taking an anticoagulant medication and she was not aware of any specified bleeding precautions warranted for</p> | F 280 | <p>therapy and precautions are care planned for those residents.</p> <p>3. All nurses will be inserviced by the Clinical Educator/DON/Clinical Manager on the need and the facility expectation to care plan anticoagulation therapy and precautions and also to include those precautions and things to look for when a resident is on an anticoagulant on the Caregiver instructions for the nurse aides to follow. The RN Admission Nurses will be inserviced by the Clinical Educator on the need to implement a care plan for anticoagulation therapy upon admission for new admits who are on an anticoagulant. All nurse aides will be inserviced by the Clinical Educator/DON/Clinical Manager regarding checking the Caregiver instructions for each resident and following the instructions for residents on anticoagulation therapy including knowing precautions and what to look for when a resident is on an anticoagulant medication. An Anticoagulant-Care Plan/Care Guide Audit tool has been created. The DON will receive a list of residents on anti-coagulants weekly from the pharmacy. The DON/Clinical Manager/RN Team Leader will review the list and complete the Audit tool weekly for 4 weeks and monthly thereafter for 3 months. Any discrepancies will be corrected upon finding and reinservice education provided as needed.</p> <p>4. The facility Quality Assurance and Performance Improvement Committee (QAPI) will review the results of the Audit tool monthly in the monthly QAPI meeting</p> | | |

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| F 280 | <p>Continued From page 2</p> <p>Resident #14. NA #1 stated Resident #14 did have observed bruising to her bilateral lower arms when she showered her this morning.</p> <p>In an interview on 9/2/15 at 12:25 PM, Nurse #1 assigned Resident #14 verified no mention that resident was on anticoagulation precautions on the September physician orders and also noted nothing on the care plan. Nurse #1 stated the only way the aides would know a resident was on a blood thinner was if the nurse informed them. Nurse #1 stated it was important for the aides rendering care to know precautions and things to look for when a resident was on an anticoagulant medication.</p> <p>In an interview on 9/2/15 at 12:52 PM, NA #2 stated she had worked at facility for ten years and she was not aware that Resident #14 was taking an anticoagulant medication but stated that information would be important to know as a precaution when caring for Resident #14.</p> <p>In an interview on 9/2/15 at 2:20 PM, the floor supervisor stated if the MDS nurse did not care plan anticoagulant medications, she did not put it on the Caregiver Instructions for the aides to know. She stated the nurse would have to inform the aide who was on a blood thinner.</p> <p>In an interview on 9/2/15 at 2:30 PM, the MDS nurse #1 stated she did not care plan residents considered stable on their anticoagulant medication. The MDS nurse verified by review of the medical record that Resident #14 was having lab work weekly to determine her blood clotting ability and anticoagulant medication adjustment ordered weekly by the physician. The MDS nurse also verified she care planned Resident #14 for</p> | F 280 | to monitor for compliance. | | |

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| F 280 | <p>Continued From page 3</p> <p>falls on 6/17/15. Nurse #16 present during this interview stated it was important for the aides to know any resident on anticoagulation therapy in order to watch for things like falls, bumps, bruising, blood in urine/stool and the use of razors.</p> <p>In an interview on 9/2/15 at 2:42 PM, MDS nurse #2 stated all residents on anticoagulation therapy should be care planned. It was at this time, MDS nurse #2 provided an updated care plan for Resident #14 for anticoagulation therapy and precautions.</p> <p>In an interview on 9/2/15 at 3:30 PM, NA # 3 and NA #4 both working on F hall confirmed using the Caregiver Instruction sheet as what they used when rendering care to Resident #14. Both aides stated they were unaware Resident #14 was taking a blood thinner and felt it was important information for them to know when providing care.</p> <p>In an interview on 9/3/15 at 12:47 PM, the director of nursing (DON) confirmed that any resident taking an anticoagulant medication should be care planned and the Caregiver Instructions include information for the aide to look for and precautions to take for any resident on a blood thinner.</p> <p>2. Resident #153 was admitted on 7/16/13 with a diagnosis of atrial fibrillation. The quarterly MDS dated 6/9/15 indicated Resident #153 had moderate cognitive impairment extensive assistance with all ADLs except for eating. The MDS assessment also indicated Resident #153 received an anticoagulant medication 7 out of 7 previous days.</p> | F 280 | | | |

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| F 280 | <p>Continued From page 4</p> <p>A review of Resident #153's medical record revealed on 8/31/15 orders included the following: Coumadin (anticoagulant) 3 mg to be given Tuesdays, Wednesdays, Fridays, Saturdays and Sundays and 4 mg to be given on Tuesdays and Thursdays with lab work to be repeated 9/4/15. The September Medication Administration Record also read the following: ANTICOAGUALTION ALERT.</p> <p>A review of Resident #153's care plan (initiated 7/16/13 and last revised 7/29/15 revealed no problem area related the use of an anticoagulant medication but Resident #153 was care planned for falls risk due unsteady gait related to Parkinson ' s disease.</p> <p>In an observation and interview with Resident #153 on 9/1/15 at 2:30 PM, there was bruising to the top of her right hand. She stated she bruised very easily because she on a blood thinner.</p> <p>In an interview on 9/2/15 at 12:20 PM, nursing assistant (NA) #1 assigned Resident #153 stated she had worked at the facility for approximately 4 months and she trained to follow the Caregiver Instructions taped to the inside of each bathroom door. NA #1 verified there was no communication on the Caregiver Instructions informing staff that Resident #153 was taking an anticoagulant medication and she was not aware of any specified bleeding precautions warranted for Resident #153.</p> <p>In an interview on 9/2/15 at 12:25 PM, Nurse #1 assigned Resident #153 verified anticoagulation precautions on the September physician orders but nothing on the care plan. Nurse #1 stated the</p> | F 280 | | | |

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| F 280 | <p>Continued From page 5</p> <p>only way the aides would know a resident was on a blood thinner was if the nurse informed them. Nurse #1 stated it was important for the aides rendering care to know precautions and things to look for when a resident was on an anticoagulant medication.</p> <p>In an interview on 9/2/15 at 12:52 PM, NA #2 stated she had worked at facility for ten years and she was not aware that Resident #153 was taking an anticoagulant medication but stated that information would be important to know as a precaution when caring for Resident #153.</p> <p>In an interview on 9/2/15 at 2:20 PM, the floor supervisor stated if the MDS nurse did not care plan anticoagulant medications, she did not put it on the Caregiver Instructions for the aides to know. She stated the nurse would have to inform the aide who was on a blood thinner.</p> <p>In an interview on 9/2/15 at 2:30 PM, the MDS nurse #1 stated she did not care plan residents considered stable on their anticoagulant medication. The MDS nurse verified by review of the medical record that Resident #153 was having lab work weekly to determine her blood clotting ability and anticoagulant medication adjustment ordered weekly by the physician. The MDS nurse also verified she care planned Resident #153 for falls on 6/17/15. Nurse #16 present during this interview stated it was important for the aides to know any resident on anticoagulation therapy in order to watch for things like falls, bumps, bruising, blood in urine/stool and the use of razors.</p> <p>In an interview on 9/2/15 at 2:42 PM, MDS nurse #2 stated all residents on anticoagulation therapy</p> | F 280 | | | |

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| F 280 | Continued From page 6 should be care planned. It was at this time, MDS nurse #2 provided an updated care plan for Resident #153 for anticoagulation therapy and precautions. In an interview on 9/2/15 at 3:30 PM, NA # 3 and NA #4 both working on F hall confirmed using the Caregiver Instruction sheet as what they used when rendering care to Resident #153. Both aides stated they were unaware Resident #14 was taking a blood thinner and felt it was important information for them to know when providing care. In an interview on 9/3/15 at 12:47 PM, the director of nursing (DON) confirmed that any resident taking an anticoagulant medication should be care planned and the Caregiver Instructions include information for the aide to look for and precautions to take for any resident on a blood thinner. | F 280 | | | |
| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer the correct pain medication as ordered by the physician for 1 of 15 residents (Resident #381) identified as having received a controlled substance (medication) borrowed from another resident. The findings included: | F 333 | 1. As noted, resident #381 denied experiencing any identifiable side effects from the pain medication she was given while at the facility. The DON initiated a medication error report and notified resident #381's physician and responsible party. 2. The DON/Clinical Manager/Clinical | 10/1/15 | |

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| | <p>Continued From page 7</p> <p>Resident #381 was admitted to the facility on 8/29/15 from a hospital with a cumulative diagnoses which included status post left total knee replacement. An admission Minimum Data Set (MDS) assessment was yet due as of the date of the review (9/3/15). Based on a review of Resident #381 ' s medical record (which included Nursing Notes and a 7-day Flow Record), the resident was assessed by staff as being alert and oriented.</p> <p>Resident #381 ' s admission medications dated 8/29/15 included: 10/325 milligrams (mg) hydrocodone / acetaminophen (a combination narcotic medication typically used for moderate to severe pain) to be given as two tablets by mouth every four hours as needed for pain; may refuse one tablet.</p> <p>A review of the Controlled Drug Records for another resident (Resident #363) revealed 10/325 mg oxycodone / acetaminophen (a different combination narcotic pain medication typically used for severe pain) was borrowed for Resident #381 on four occasions: --On 8/30/15 at 9:55 AM, two tablets of 10/325 mg oxycodone/acetaminophen were borrowed from Resident #363 for Resident #381 (identified on the Controlled Drug Record by a room assignment only); --On 8/30/15 at 2:00 PM, two tablets of 10/325 mg oxycodone/ acetaminophen were borrowed from Resident #363 for Resident #381 (identified on the Controlled Drug Record by a room assignment only); --On 8/30/15 at 11:00 PM, two tablets of 10/325 mg oxycodone/ were acetaminophen borrowed from Resident #363 for Resident #381 (identified</p> | | <p>Educator will conduct a 100% in house audit of the Medication Administration Records by 10/1/15 to determine if any other medication errors occurred as a result of the borrowing and will create medication error reports if any errors are found.</p> <p>3. Nurses #13 and #14 will be given a one to one inservice by the Clinical Educator on the facility's policy on Medication Administration Guidelines including information that controlled medications may not be borrowed. All other nurses and new nurses will be inserviced as well. All nurses and new nurses will be inserviced by the Pharmacy Consultant/Clinical Educator/DON on the eight rights of medication administration to include ensuring the right medication is given to the right resident. All inservices will be completed by 10/1/15. The DON/Clinical Manager/Team Leader will conduct a random audit of 5 Medication Administration Records per hall daily for one week then weekly for eight weeks to check for medication errors and/or documentation of borrowing. They will utilize the newly created Narcotic Documentation Audit. Any discrepancies will be corrected upon finding and reinservice education provided as needed.</p> <p>4. The facility's QAPI Committee will review the results of the Narcotic Documentation Audit tool monthly in the monthly QAPI meeting to monitor for compliance for three months. The consultant pharmacist will also monitor for compliance for three months during his monthly visits utilizing the Monthly</p> | | |

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| F 333 | <p>Continued From page 8 on the Controlled Drug Record by a room assignment only); --On 8/31/15 at 10:15 AM, one tablet of 10/325 mg oxycodone/acetaminophen was borrowed from Resident #363 for Resident #381 (identified on the Controlled Drug Record by a room assignment only).</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurses ' signatures on the Controlled Drug Record and began the process of determining which resident the medication(s) were borrowed. The resident receiving the borrowed medication(s) was identified on the Controlled Drug Record by the room assignment only (not a name).</p> <p>A follow up interview was conducted with the facility ' s DON on 9/3/15 at 2:10 PM. Upon the identification of Resident #381 and a review of her medical record, the DON confirmed the</p> | F 333 | <p>Consultant Pharmacist Activity Report and notify the DON/Administrator of his findings during monthly exit meetings.</p> | | |

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| F 333 | <p>Continued From page 9</p> <p>resident had been prescribed 10/325 mg hydrocodone / acetaminophen as a pain medication (not the 10/325 mg oxycodone / acetaminophen borrowed for the resident on four separate occasions). The DON acknowledged the use of oxycodone/acetaminophen was a medication error for this resident. She reported the facility would initiate a medication error report, notify Resident #381 's physician and her Responsible Party, and implement corrective measures as needed. The DON also indicated the nurse who administered the oxycodone / acetaminophen on 3 of the 4 occasions had just been interviewed by her (the DON) and reportedly admitted to making an error.</p> <p>Interviews were conducted on 9/3/15 at 9:55 AM and 2:20 PM with Nurse #13. Nurse #13 was identified as the nurse who borrowed the oxycodone / acetaminophen medication from Resident #363 and administered it to Resident #381 on three of the four occasions identified (8/30/15 at 9:55 AM; 8/30/15 at 2:00 PM; and 8/31/15 at 10:15 AM). Upon inquiry, Nurse #13 acknowledged she reviewed Resident #381 's medical record with the DON and confirmed she had made an error by giving Resident #381 the wrong pain medication on each of these three occasions. The nurse stated, "I screwed up." When asked, Nurse #13 reported she did not recall the resident becoming sedated or experiencing any adverse effects from the wrong pain medication given on the dates in question.</p> <p>An interview was conducted on 9/3/15 at 2:30 PM with Resident #381. Resident #381 reported she did experience significant pain after her surgery, which was effectively treated with the pain medication(s) received. Upon inquiry, the</p> | F 333 | | | |

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| F 333 | Continued From page 10 resident denied experiencing any identifiable side effects (including sedation) from the pain medication she was given while at the facility. A telephone interview was conducted on 9/3/2015 at 3:18 PM with Nurse #14. Nurse #14 was the nurse identified as borrowing oxycodone / acetaminophen from Resident #363 and administering it to Resident #381 on 8/30/15 at 11:00 PM. Upon inquiry, Nurse #14 recalled borrowing the pain medication for Resident #381 just prior to the conclusion of her shift that night. The nurse stated she was not aware that the wrong medication was administered to Resident #381 at that time. However, she reported she knew hydrocodone / acetaminophen and oxycodone / acetaminophen were different medications and were not interchangeable. An interview was conducted on 9/3/2015 at 3:54 PM with the facility 's DON. During the interview, the DON stated her expectation was for a nurse to follow the physician 's medication orders and to check each medication with the resident 's Medication Administration Record (MAR) to ensure accuracy prior to medication administration. | F 333 | | | |
| 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. | F 425 | | 10/1/15 | |

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| F 425 | <p>Continued From page 11</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, pharmacy staff interviews and record review, the facility failed to follow established procedures for the acquisition of narcotic medications to ensure that controlled substances (medications) belonging to one resident were not "borrowed" or used for administration to another resident for 15 of 69 residents (Residents #363, #377, #383, #384, #38, #380, #382, #387, #381, #174, #134, #375, #378, #215, and #150) receiving controlled substances at the time of the survey investigation.</p> <p>The findings included:</p> <p>1) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency.</p> | F 425 | <p>1. None of the residents identified suffered any known untoward side effects as a result of receiving "borrowed" medications or having medications "borrowed" from them.</p> <p>2. The Clinical Educator conducted inservice education for the nurses upon notification of the findings by the surveyors. The inservice included the requirement that controlled medications may not be borrowed and the procedures to follow if a controlled medication is not available such as use the Pyxis system, call the back up pharmacy, notify doctor for an available alternative. Eighteen nurses received the inservice education on 9/2 and 9/3/15.</p> <p>3. All nurses including Nurses #2,#3,#4,#5,#7,#8,#9, and #15, will be inserviced on the facility's policy on Medication Administration Guidelines including the section related to "Controlled medications may not be borrowed even in</p> | | |

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| F 425 | <p>Continued From page 12</p> <p>In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #363 was admitted to the facility on 8/5/15. A review of the resident ' s medical record revealed his medication orders included the following: 5/325 milligrams (mg) oxycodone / acetaminophen (a combination narcotic pain medication) given as two tablets by mouth every 4 hours as needed for pain; may refuse one tablet (ordered on 8/5/15).</p> <p>A review of Resident #363 ' s Controlled Drug Records revealed that the last tablet of the resident ' s 5/325 mg oxycodone/acetaminophen was used on 8/18/15 at 6:40 PM. The Controlled Drug Records also indicated a refill of the 5/325 mg oxycodone/acetaminophen tablets was received from the pharmacy on 8/18/15 (no time provided).</p> <p>A review of Resident #376 ' s Controlled Drug Records revealed on 8/18/15 at 7:30 PM, one tablet of 5/325 mg oxycodone/acetaminophen dispensed for Resident #376 was signed out by a nurse and noted as " borrowed for (Resident #363). " Further review of Resident #376 ' s Controlled Drug Records revealed on 8/18/15 at 11:00 PM, two tablets of 5/325 mg oxycodone/acetaminophen dispensed for Resident #376 were signed out by a nurse and noted as " borrowed for (Resident #363). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as</p> | F 425 | <p>an emergency." All nurses will be inserviced on the protocol and procedures for ordering or reordering controlled medications in the event a resident is out of the medication including utilizing the Pyxis machine to obtain the medication. All inservices will be completed by 10/1/15. An audit tool for "Controlled Substances/Ordering and Receiving" has been created which includes residents name,date of prescription, date and time prescription sent to the pharmacy, date and time medication received, and what was the follow up if the medication was not received. The audit will include all new controlled substance prescriptions obtained during the 7-3 AM shift. The 3-11PM shift RN Team Leader will complete the audit daily for one week, then twice a week for eight weeks. Any discrepenices identified such as issues with the medication not arriving or the Pixys not being used to obtain the medication will be corrected at that time via inservices and/or obtaining the medication from the back up pharmacy. The DON/Clinical Manager/RN Team Leaders will audit the controlled drug records via the new "Narcotic Documentation Audit" tool daily for one week, then twice a week for eight weeks to ensure there are no documented instances of "borrowing" narcotics.</p> <p>4. The facility's QAPI Committee will review the results of the Contolled Substance audit tool and the Narcotic Documentation Audit tool in the monthly QAPI committed meeting to monitor for compliance for three months. The</p> | | |

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| F 425 | <p>Continued From page 13</p> <p>having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues</p> | F 425 | <p>consultant pharmacist will also monitor for compliance for three months during his monthly visits utilizing the Monthly Consultant Pharmacist Activity Report and notify the DON/Administrator.</p> | | |

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| F 425 | <p>Continued From page 14 of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility 's contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>A telephone interview was conducted on 9/3/15 at 1:06 PM with Nurse #2. Nurse #2 was the nurse identified by the signature on the Controlled Drug Record as having borrowed oxycodone/acetaminophen from Resident #376 to</p> | F 425 | | | |

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| F 425 | <p>Continued From page 15</p> <p>Resident #363 on two separate occasions on 8/18/15. Upon inquiry, the nurse acknowledged she had borrowed controlled substance medications from one resident to another on occasions. Nurse #2 outlined the facility ' s procedures for obtaining a resident ' s medication. She stated if a resident needed a physician-ordered medication that was not currently available for him/her, she first looked for the medication in the facility ' s Pyxis machine; then would call the backup pharmacy to request the medication. Nurse #2 reported the borrowing of controlled substance medications, " was not a practice. " However, the nurse indicated if the pain medication ordered for a resident was not available from the Pyxis or backup pharmacy in a timely manner, she would go ahead and borrow a medication from another resident. Nurse #2 acknowledged she knew she was not supposed to borrow medications from one resident to another.</p> <p>2) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #377 was admitted to the facility on 8/18/15. A review of the resident ' s medical record revealed her medication orders included the following: 5/325 milligrams (mg) oxycodone / acetaminophen (a combination narcotic pain medication) given as two tablets by mouth every</p> | F 425 | | | |

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| F 425 | <p>Continued From page 16</p> <p>4 hours as needed for pain; may refuse one tablet (ordered on 8/18/15).</p> <p>A review of Resident #376 ' s Controlled Drug Records revealed on 8/18/15 at 10:15 PM, two-5/325 mg oxycodone/acetaminophen tablets dispensed for Resident #376 were signed out by a nurse and noted as " borrowed for (Resident #377). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015</p> | F 425 | | | |

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| F 425 | <p>Continued From page 17 at 1:34 PM with the facility ' s Consultant Pharmacist. Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription</p> | F 425 | | | |

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| F 425 | <p>Continued From page 18</p> <p>and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>A telephone interview was conducted on 9/3/15 at 1:06 PM with Nurse #2. Nurse #2 was the nurse identified by the signature on the Controlled Drug Record as having borrowed oxycodone/acetaminophen from Resident #376 to Resident #377 on 8/18/15 at 10:15 PM. Upon inquiry, the nurse acknowledged she had borrowed controlled substance medications from one resident to another on occasions. Nurse #2 outlined the facility ' s procedures for obtaining a resident ' s medication. She stated if a resident needed a physician-ordered medication that was not currently available for him/her, she first looked for the medication in the facility ' s Pyxis machine; then would call the backup pharmacy to request the medication. Nurse #2 reported the borrowing of controlled substance medications, " was not a practice. " However, the nurse indicated if the pain medication ordered for a resident was not available from the Pyxis or backup pharmacy in a timely manner, she would go ahead and borrow a medication from another resident. Nurse #2 acknowledged she knew she was not supposed to borrow medications from one resident to another.</p> <p>3) A review of the facility ' s policy on " Medication Administration Guidelines " (revised</p> | F 425 | | | |

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| F 425 | <p>Continued From page 19</p> <p>January 2013) included a section titled, II. Documentation, which read, in part:</p> <p>B. Medications Scheduled But Not Administered</p> <p>3. Medications Not Available</p> <p>(a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #383 was admitted to the facility on 8/19/15. A review of the resident ' s medical record revealed her medication orders included the following: 5/325 milligrams (mg) oxycodone / acetaminophen (a combination narcotic pain medication) given as one tablet by mouth twice daily as needed for pain (ordered on 8/19/15).</p> <p>A review of Resident #363 ' s Controlled Drug Records revealed on 8/19/15 at 9:00 PM, one 5/325 mg hydrocodone/acetaminophen tablet dispensed for Resident #363 was signed out by a nurse and noted as " borrowed for (Resident #383). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for</p> | F 425 | | | |

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| F 425 | <p>Continued From page 20</p> <p>emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for</p> | F 425 | | | |

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| F 425 | <p>Continued From page 21</p> <p>residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>A telephone interview was conducted on 9/3/15 at 1:06 PM with Nurse #2. Nurse #2 was the nurse identified by the signature on the Controlled Drug Record as having borrowed oxycodone / acetaminophen from Resident #363 to Resident #383 on 8/19/15. Upon inquiry, the nurse acknowledged she had borrowed controlled substance medications from one resident to another on occasions. Nurse #2 outlined the facility ' s procedures for obtaining a resident ' s medication. She stated if a resident needed a physician-ordered medication that was not currently available for him/her, she first looked for the medication in the facility ' s Pyxis machine;</p> | F 425 | | | |

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| F 425 | <p>Continued From page 22</p> <p>then would call the backup pharmacy to request the medication. Nurse #2 reported the borrowing of controlled substance medications, " was not a practice. " However, the nurse indicated if the pain medication ordered for a resident was not available from the Pyxis or backup pharmacy in a timely manner, she would go ahead and borrow a medication from another resident. Nurse #2 acknowledged she knew she was not supposed to borrow medications from one resident to another.</p> <p>4) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #384 was admitted to the facility on 8/19/15. A review of the resident ' s medical record revealed her medication orders included the following: 5/325 milligrams (mg) oxycodone / acetaminophen (a combination narcotic pain medication) given as one and ½ tablets by mouth every four hours as needed for pain; may refuse ½ or one tablet (ordered on 8/19/15).</p> <p>A review of Resident #363 ' s Controlled Drug Records revealed on 8/19/15 at 10:00 PM, one 5/325 mg oxycodone/acetaminophen tablet dispensed for Resident #363 was signed out by a nurse and noted as " borrowed for (Resident #384). "</p> | F 425 | | | |

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| F 425 | <p>Continued From page 23</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not</p> | F 425 | | | |

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| F 425 | <p>Continued From page 24</p> <p>acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> | F 425 | | | |

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| F 425 | Continued From page 25 A telephone interview was conducted on 9/3/15 at 1:06 PM with Nurse #2. Nurse #2 was the nurse identified by the signature on the Controlled Drug Record as having borrowed oxycodone/acetaminophen from Resident #363 to Resident #384 on 8/19/15 at 10:00 PM. Upon inquiry, the nurse acknowledged she had borrowed controlled substance medications from one resident to another on occasions. Nurse #2 outlined the facility ' s procedures for obtaining a resident ' s medication. She stated if a resident needed a physician-ordered medication that was not currently available for him/her, she first looked for the medication in the facility ' s Pyxis machine; then would call the backup pharmacy to request the medication. Nurse #2 reported the borrowing of controlled substance medications, " was not a practice. " However, the nurse indicated if the pain medication ordered for a resident was not available from the Pyxis or backup pharmacy in a timely manner, she would go ahead and borrow a medication from another resident. Nurse #2 acknowledged she knew she was not supposed to borrow medications from one resident to another. 5) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. " Resident #38 was admitted to the facility on | F 425 | | | |

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| F 425 | <p>Continued From page 26</p> <p>8/1/15. A review of the resident ' s medical record revealed his medication orders included the following: 5 (mg) oxycodone (a narcotic pain medication) given as 1 tablet by mouth every 4 hours as needed for pain (ordered on 8/14/15).</p> <p>A review of Resident #240 ' s Controlled Drug Records revealed on 8/22/15 at 10:20 PM, 2 one-half tablets (containing 2.5 mg oxycodone each) dispensed for Resident #240 were signed out by a nurse and noted as " borrowed for (Resident #38). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug</p> | F 425 | | | |

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| F 425 | <p>Continued From page 27 Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would</p> | F 425 | | | |

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| F 425 | <p>Continued From page 28</p> <p>automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>A telephone interview was conducted on 9/3/15 at 1:06 PM with Nurse #2. Nurse #2 was the nurse identified by the signature on the Controlled Drug Record as having borrowed oxycodone from Resident #240 to Resident #38 on 8/22/15. Upon inquiry, the nurse acknowledged she had borrowed controlled substance medications from one resident to another on occasions. Nurse #2 outlined the facility ' s procedures for obtaining a resident ' s medication. She stated if a resident needed a physician-ordered medication that was not currently available for him/her, she first looked for the medication in the facility ' s Pyxis machine; then would call the backup pharmacy to request the medication. Nurse #2 reported the borrowing of controlled substance medications, " was not a practice. " However, the nurse indicated if the pain medication ordered for a resident was not available from the Pyxis or backup pharmacy in a timely manner, she would go ahead and borrow a medication from another resident. Nurse #2 acknowledged she knew she was not supposed to borrow medications from one resident to another.</p> | F 425 | | | |

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| F 425 | <p>Continued From page 29</p> <p>6) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #380 was admitted to the facility on 8/15/15. A review of the resident ' s medical record revealed her medication orders included the following: 10/325 milligrams (mg) hydrocodone / acetaminophen (a combination narcotic pain medication) given as one tablet by mouth every 6 hours as needed for pain (ordered on 8/15/15).</p> <p>A review of Resident #379 ' s Controlled Drug Records revealed on 8/16/15 at 1:30 PM, one tablet of 10/325 mg hydrocodone/acetaminophen dispensed for Resident #379 was signed out by a nurse and noted as " borrowed for (Resident #380). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of</p> | F 425 | | | |

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| F 425 | <p>Continued From page 30</p> <p>narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist. Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During</p> | F 425 | | | |

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| F 425 | <p>Continued From page 31</p> <p>this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>An interview was not conducted with Nurse #4. An attempt was made to contact the nurse by telephone on 9/3/15 at 11:20 AM with a request for return call; the call was not returned. Nurse #4 was the nurse identified by the signature on the Controlled Drug Record as having borrowed hydrocodone / acetaminophen from Resident #379 to Resident #380 on 8/16/15.</p> <p>7) A review of the facility ' s policy on " Medication Administration Guidelines " (revised</p> | F 425 | | | |

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| F 425 | <p>Continued From page 32</p> <p>January 2013) included a section titled, II. Documentation, which read, in part:</p> <p>B. Medications Scheduled But Not Administered</p> <p>3. Medications Not Available</p> <p>(a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #382 was admitted to the facility on 8/26/15. A review of the resident ' s medical record revealed her medication orders included the following: 10/325 milligrams (mg) hydrocodone / acetaminophen (a combination narcotic pain medication) given as one tablet by mouth twice daily as needed for pain (ordered on 8/26/15).</p> <p>A review of Resident #379 ' s Controlled Drug Records revealed on 8/26/15 at 8:00 PM, one 10/325 mg hydrocodone/acetaminophen tablet dispensed for Resident #379 was signed out by a nurse and noted as " borrowed for (Resident #382). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing</p> | F 425 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345369 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 09/03/2015 |
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| F 425 | <p>Continued From page 33</p> <p>controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist. Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or</p> | F 425 | | | |

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| F 425 | <p>Continued From page 34</p> <p>reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>An interview was conducted on 9/2/2015 at 6:05 PM with Nurse #9. Nurse #9 was the nurse identified by the signature on the Controlled Drug Record as having borrowed hydrocodone / acetaminophen from Resident #379 to Resident #382 on 8/26/15. During the interview, Nurse #9 described the procedures followed when a resident ' s controlled substance medication was not available for use when needed. The nurse indicated she would first check the medication cart for the med ' s availability, then she would check the Pyxis machine. If the medication was still not available, she would call the pharmacy or</p> | F 425 | | | |

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| F 425 | <p>Continued From page 35</p> <p>backup pharmacy to request delivery. Nurse #9 also noted she could call the resident ' s physician to see if an alternative pain medication would be appropriate for use. However, the nurse reported she could not recall whether or not she contacted the physician for Resident #382 on 8/26/15. Nurse #9 stated she knew it was not allowed for a controlled substance medication to be borrowed from one resident to another, but indicated she opted to do so because the resident was in pain.</p> <p>8) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #387 was admitted to the facility on 8/17/15. A review of the resident ' s medical record revealed her medication orders included the following: 5/325 milligrams (mg) hydrocodone / acetaminophen (a combination narcotic pain medication) given as two tablets by mouth every 4 hours as needed for pain; may refuse one tablet (ordered on 8/17/15).</p> <p>A review of Resident #64 ' s Controlled Drug Records revealed on 8/18/15 at 12:20 AM, two-5/325 mg hydrocodone/acetaminophen tablets dispensed for Resident #64 were signed out by a nurse and noted as " borrowed for (Resident #387). "</p> | F 425 | | | |

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| F 425 | <p>Continued From page 36</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not</p> | F 425 | | | |

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| F 425 | <p>Continued From page 37</p> <p>acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> | F 425 | | | |

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| F 425 | <p>Continued From page 38</p> <p>A telephone interview was conducted on 9/3/2015 at 9:24 AM with Nurse #5. Nurse #5 was the nurse identified by the signature on the Controlled Drug Record as having borrowed hydrocodone / acetaminophen from Resident #64 to Resident #387 on 8/18/15 at 12:20 AM. During the interview, the nurse recalled this incident of borrowing a narcotic pain medication. The nurse reported sometimes there were problems when a resident ' s medications had not yet come in from the pharmacy. She indicated when this happened, she would check the Pyxis machine to see if the resident ' s prescribed medication was available; if it was not, she would call the backup pharmacy. The nurse stated sometimes it could be " a while " before the medication was delivered from the backup pharmacy. In this case, the pain medication ordered was not available and the resident was requesting it; so she borrowed the medication from another resident.</p> <p>9) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #381 was admitted to the facility on 8/29/15. A review of the resident ' s medical record revealed her medication orders included the following: 5/325 milligrams (mg) hydrocodone / acetaminophen (a combination narcotic pain</p> | F 425 | | | |

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| F 425 | <p>Continued From page 39 medication) given as two tablets by mouth every 4 hours as needed for moderate-severe pain; may refuse one tablet (ordered on 8/31/15).</p> <p>A review of Resident #366 ' s Controlled Drug Records revealed on 8/31/15 at 9:50 PM, two-5/325 mg hydrocodone/acetaminophen tablets dispensed for Resident #366 were signed out by a nurse and noted as " borrowed for (Resident #381). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> | F 425 | | | |

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| F 425 | <p>Continued From page 40</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a</p> | F 425 | | | |

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| F 425 | <p>Continued From page 41</p> <p>courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>An interview was not conducted with Nurse #4. An attempt was made to contact the nurse by telephone on 9/3/15 at 11:20 AM with a request for a return call; the call was not returned. Nurse #4 was the nurse identified by the signature on the Controlled Drug Record as having borrowed hydrocodone / acetaminophen from Resident #366 to Resident #381 on 8/31/15.</p> <p>10) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #174 was admitted to the facility on 8/22/15. A review of the resident ' s medical record revealed her medication orders included the following: 50 milligrams (mg) tramadol given as one tablet every 6 hours as needed for pain (ordered on 8/22/15).</p> | F 425 | | | |

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| F 425 | <p>Continued From page 42</p> <p>A review of Resident #386 ' s Controlled Drug Records revealed on 8/23/15 at 3:15 PM, a 50 mg tablet of tramadol dispensed for Resident #386 was signed out by a nurse and noted as " borrowed for (Resident #174). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist. Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of</p> | F 425 | | | |

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| F 425 | <p>Continued From page 43</p> <p>controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and</p> | F 425 | | | |

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| F 425 | <p>Continued From page 44</p> <p>up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>An interview was not conducted with Nurse #8 during the on-site recertification survey. An attempt was made to contact the nurse by telephone on 9/3/15 at 10:38 AM and a message was left with a request for a return call. The call was not returned prior to exit from the facility. Nurse #8 was the nurse identified by the signature on the Controlled Drug Record as having borrowed tramadol from Resident #386 to Resident #174 on 8/23/15.</p> <p>11) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #134 was admitted to the facility on 8/19/15. A review of the resident ' s medical record revealed her medication orders included the following: 50 milligrams (mg) tramadol (an opioid pain medication) given as one tablet by mouth every 6 hours as needed for pain (ordered on 8/19/15).</p> <p>A review of Resident #379 ' s Controlled Drug Records revealed on 8/25/15 at 1:25 AM, one 50</p> | F 425 | | | |

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| F 425 | <p>Continued From page 45</p> <p>mg tablet of tramadol dispensed for Resident #379 was signed out by a nurse and noted as " borrowed for (Resident #134). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and</p> | F 425 | | | |

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| F 425 | <p>Continued From page 46</p> <p>March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an</p> | F 425 | | | |

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| F 425 | <p>Continued From page 47</p> <p>in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>A telephone interview was conducted on 9/3/2015 at 9:24 AM with Nurse #5. Nurse #5 was the nurse identified by the signature on the Controlled Drug Record as having borrowed tramadol from Resident #379 to Resident #134 on 8/25/15. During the interview, the nurse recalled this incident of borrowing a narcotic pain medication. The nurse reported sometimes there were problems when a resident ' s medications had not yet come in from the pharmacy. She indicated when this happened, she would check the Pyxis machine to see if the resident ' s prescribed medication was available; if it was not, she would call the backup pharmacy. The nurse stated sometimes it could be " a while " before the medication was delivered from the backup pharmacy. In this case, the pain medication ordered was not available and the resident was requesting it, so she borrowed the medication from another resident.</p> <p>12) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #375 was admitted to the facility on 8/25/15. A review of the resident ' s medical</p> | F 425 | | | |

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| F 425 | <p>Continued From page 48</p> <p>record revealed her medication orders included the following: 50 milligrams (mg) tramadol (an opioid pain medication) given as one tablet by mouth every 6 hours as needed for pain (ordered on 8/25/15).</p> <p>A review of Resident #374 ' s Controlled Drug Records revealed on 8/26/15 at 2:00 PM, 2 one-half tablets (containing 25 mg tramadol each) dispensed for Resident #374 were signed out by a nurse and noted as " borrowed for (Resident #375). " Further review of the Controlled Drug Records revealed on 8/26/15 at 9:00 PM, 2 one-half tablets (containing 25 mg tramadol each) dispensed for Resident #374 were signed out by a nurse and noted as " borrowed for (Resident #375). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016.</p> | F 425 | | | |

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| F 425 | <p>Continued From page 49</p> <p>In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurses ' signatures on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was</p> | F 425 | | | |

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| F 425 | <p>Continued From page 50</p> <p>6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>An interview was conducted on 9/3/2015 at 9:32 AM with Nurse #3. Nurse #3 was the nurse identified by the signature on the Controlled Drug Record as having borrowed tramadol from Resident #374 to Resident #375 on 8/26/15 at 2:00 PM. Upon inquiry, the nurse stated she recalled borrowing a controlled substance medication for Resident #375. Nurse #3 acknowledged the in-house Pyxis machine contained controlled substance medications for emergency use. However, she reported two nurses were required to sign controlled substances out of the Pyxis machine and sometimes the 2nd nurse wasn't available to assist with obtaining the medication. Nurse #3 reported time constraints may have occasionally prohibited her from checking the Pyxis machine for the medication availability and/or calling the backup pharmacy prior to borrowing a controlled substance medications from another resident.</p> | F 425 | | | |

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| F 425 | <p>Continued From page 51</p> <p>A telephone interview was conducted on 9/3/15 at 1:06 PM with Nurse #2. Nurse #2 was the nurse identified by the signature on the Controlled Drug Record as having borrowed tramadol from Resident #374 to Resident #375 on 8/26/15 at 9:00 PM. Upon inquiry, the nurse acknowledged she had borrowed controlled substance medications from one resident to another on occasions. Nurse #2 outlined the facility ' s procedures for obtaining a resident ' s medication. She stated if a resident needed a physician-ordered medication that was not currently available for him/her, she first looked for the medication in the facility ' s Pyxis machine; then would call the backup pharmacy to request the medication. Nurse #2 reported the borrowing of controlled substance medications, " was not a practice. " However, the nurse indicated if the pain medication ordered for a resident was not available from the Pyxis or backup pharmacy in a timely manner, she would go ahead and borrow a medication from another resident. Nurse #2 acknowledged she knew she was not supposed to borrow medications from one resident to another.</p> <p>13a) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #378 was admitted to the facility on</p> | F 425 | | | |

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| F 425 | <p>Continued From page 52</p> <p>8/8/15. A review of the resident ' s medical record revealed her medication orders included the following: 50 milligrams (mg) tramadol given as one tablet every 6 hours as needed for pain; may use own supply (ordered on 8/8/15).</p> <p>A review of Resident #365 ' s Controlled Drug Records revealed on 8/22/15 at 5:30 AM, a 50 mg tablet of tramadol dispensed for Resident #365 was signed out by a nurse and noted as " borrowed for (Resident #378). " Further review of the Controlled Drug Records for Resident #365 revealed on 8/23/15 at 8:20 PM, a 50 mg tablet of tramadol dispensed for Resident #365 was signed out by a nurse and noted as " borrowed for (Resident #378). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance</p> | F 425 | | | |

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| F 425 | <p>Continued From page 53</p> <p>medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurses ' signatures on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested</p> | F 425 | | | |

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| F 425 | <p>Continued From page 54</p> <p>as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>A telephone interview was conducted on 9/3/15 at 10:23 AM with Nurse #7. Nurse #7 was the nurse identified by the signature on the Controlled Drug Record DON as having borrowed tramadol from Resident #365 to Resident #378 on 8/22/15. Upon inquiry, Nurse #7 recalled the instance of borrowing a controlled substance medication from one resident to another. The nurse recalled he had checked the facility ' s Pyxis machine to see if the tramadol was available there and it was not. He also reported calling the backup pharmacy to request a delivery of the medication. However, the nurse stated from past experience he knew it typically took 2-4 hours to receive a controlled substance medication from the back-up pharmacy. The nurse stated that he knew he wasn't supposed to, but he felt the resident needed the pain medication and could not wait for the back-up pharmacy to deliver it.</p> <p>An interview was not conducted with Nurse #8</p> | F 425 | | | |

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| F 425 | <p>Continued From page 55 during the on-site recertification survey. An attempt was made to contact the nurse by telephone on 9/3/15 at 10:38 AM and a message was left with a request for a return call. The call was not returned prior to exit from the facility. Nurse #8 was the nurse identified by the signature on the Controlled Drug Record as having borrowed tramadol from Resident #365 to Resident #378 on 8/23/15.</p> <p>13b) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #378 was admitted to the facility on 8/8/15. A review of the resident ' s medical record revealed her medication orders included the following: 0.25 milligrams (mg) alprazolam (an antianxiety medication) given by mouth twice daily as needed for anxiety (ordered on 8/8/15).</p> <p>A review of Resident #385 ' s Controlled Drug Records revealed on 8/24/15 at 1:00 PM, a 0.25 mg tablet of alprazolam dispensed for Resident #385 was signed out by a nurse and noted as " borrowed for (Resident #378). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to</p> | F 425 | | | |

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| F 425 | <p>Continued From page 56</p> <p>the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON</p> | F 425 | | | |

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| F 425 | <p>Continued From page 57</p> <p>acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>An interview was conducted on 9/2/2015 at 3:25 PM with Nurse #6. Nurse #6 was the nurse identified by the signature on the Controlled Drug Record as having borrowed alprazolam from Resident #385 to Resident #378 on 8/24/15 at 1:00 PM. During the interview, the nurse outlined the procedures followed when a medication was not available for administration to a resident. Nurse #6 stated if the ordered controlled substance medication was not in the medication cart for a resident, the nurse was supposed to go to the Pyxis machine to see if she could obtain the medication from there. If it was not available in the Pyxis machine, then the nurse would need to call the pharmacy or backup pharmacy for delivery of the medication. Nurse #6 reported that depending on the severity of the situation, she may have opted to borrow a controlled substance from another resident if the resident requiring the medication did not feel he/she could wait for it.</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility 's contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested</p> | F 425 | | | |

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| F 425 | <p>Continued From page 58</p> <p>as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>14) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #215 was re-admitted to the facility on 8/14/15. A review of the resident ' s medical record revealed her medication orders included the following: 0.25 milligrams (mg) lorazepam (an antianxiety medication) given by mouth twice daily (ordered on 8/14/15).</p> <p>A review of Resident #71 ' s Controlled Drug Records revealed on 8/19/15 at 10:00 PM, one-half of a 0.5 mg tablet of lorazepam</p> | F 425 | | | |

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| F 425 | <p>Continued From page 59</p> <p>dispensed for Resident #71 was signed out by a nurse and noted as " borrowed for (Resident #215). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug Record.</p> <p>An interview was conducted on 9/2/15 at 11:50 AM with Nurse #15. Nurse #15 was the nurse identified by the signature on the Controlled Drug Record as having borrowed lorazepam from Resident #71 to Resident #215 on 8/19/15. During the interview, the nurse reported if a resident had an order for a controlled substance</p> | F 425 | | | |

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| F 425 | <p>Continued From page 60</p> <p>that was not on the medication cart, she was supposed to let the team leader know and go to the Pyxis machine to acquire it. This procedure required a second nurse ' s signature to sign the medication out. However, if the controlled medication was not in the Pyxis, she looked for another patient that had it and borrowed the medication from him/her, noting the borrowing on the Controlled Drug Record. When asked if it was her understanding the borrowing of narcotic medications was acceptable, the nurse stated, "Yeah." She added, " The pharmacy said we are not supposed to borrow, but if a patient needs it we go ahead and borrow it. "</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager</p> | F 425 | | | |

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| F 425 | <p>Continued From page 61</p> <p>reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident.</p> <p>15) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, II. Documentation, which read, in part: B. Medications Scheduled But Not Administered 3. Medications Not Available (a) " Controlled Medications - May not be borrowed even in an emergency. In an emergency, the facility ' s controlled substance kit should be utilized. "</p> <p>Resident #150 was admitted to the facility on</p> | F 425 | | | |

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| F 425 | <p>Continued From page 62</p> <p>7/7/15. A review of the resident ' s medical record revealed her medication orders included the following: 5 milligrams (mg) zolpidem (a hypnotic medication) given as one-half tablet (2.5 mg) by mouth at bedtime as needed for sleep (ordered on 7/8/15).</p> <p>A review of Resident #1 ' s Controlled Drug Records revealed on 8/14/15 at 12:00 AM, one-half of a 5 mg zolpidem tablet dispensed for Resident #1 was signed out by a nurse and noted as " borrowed for (Resident #150). "</p> <p>An interview was conducted with the facility ' s Director of Nursing (DON) on 9/2/15 at 11:20 AM. The DON reported the facility recognized there were concerns in regards to the borrowing of controlled substance medications. According to the DON, part of the problem was identified as having a delay in the receipt of medications ordered and having " some issues " with the backup pharmacy, particularly for new admissions on the rehabilitation halls of the facility. The DON discussed the facility ' s procedure for the ordering (and re-ordering) of narcotic medications. She noted the facility had a small in-house Pyxis machine containing controlled substance medications intended for emergency use; and, these medications could be used when there was a delay in the delivery of a resident ' s medication(s). The DON also reported the facility had plans to transition over to a different contract pharmacy (and back-up pharmacy) between January and March of 2016. In regards to borrowing controlled substance medications from one resident to another, the DON stated, " That is not our practice or our policy. " The DON assisted in identifying the nurse ' s signature on the Controlled Drug</p> | F 425 | | | |

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| F 425 | <p>Continued From page 63 Record.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:34 PM with the facility ' s Consultant Pharmacist.</p> <p>Upon inquiry, the pharmacist reported he had discussed concerns regarding the borrowing of controlled substances with the DON in the past. He reported addressing the issue in February and March 2015 (with the former DON), and most recently in July and August 2015 with the current DON. He recalled having an in-service in June 2015 when he, " made it loud and clear it was not acceptable to borrow medications, especially controlled substances. "</p> <p>A follow-up interview was conducted on 9/2/2015 at 3:10 PM with the DON. At that time, the DON acknowledged she had been aware of the issues of "borrowed" narcotics (controlled substance medications), but did not realize it was "that bad."</p> <p>A telephone interview was conducted on 9/2/15 at 4:04 PM with the Assistant Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Assistant Pharmacy Manager reviewed the procedures for ordering or reordering controlled substance medications for residents. The Assistant Manager reported the process involved faxing the pharmacy a written or hard copy of the signed prescription. Once received, the medication would be sent out. He indicated the cut-off time for request of a controlled substance for same-day delivery was 6:30 PM. Unless the medication was requested as a STAT (urgent) medication, the medication would be received by the facility around 10:00 PM. If the order for a medication was placed after 6:30 PM, the pharmacy phone would</p> | F 425 | | | |

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| F 425 | Continued From page 64 automatically roll over to an on-call pharmacy service. This service could arrange to have a courier pick up the hard copy of the prescription and take it to a contracted retail pharmacy. Upon inquiry as to how long this process would take before the medication was received, he stated, " Realistically, maybe 1 and 1/2 hours or so ...and up to a couple of hours. " The Assistant Manager also reported the facility had an in-house Pyxis machine. He noted the Pyxis machine contained a stock of certain controlled medications for emergency use and was intended to help meet the immediate needs of a resident. | F 425 | | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. | F 431 | | 10/1/15 | |

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| F 431 | <p>Continued From page 65</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to consistently follow established procedures for the accounting of controlled substance medications for 2 of 4 sampled residents (Resident #252, and #176) receiving controlled substances prescribed on an as needed basis.</p> <p>1a) Resident #252 was admitted to the facility on 8/27/14. A review of Resident #252 ' s medication orders included the following: 5 milligrams (mg) oxycodone (an opioid pain medication) given as one tablet by mouth every 4 hours as needed. Oxycodone is a controlled substance medication.</p> <p>A review of Resident #252 ' s August 2015 Medication Administration Record (MAR) indicated oxycodone was administered to</p> | F 431 | <p>1. Resident's #252 and #176 experienced no untoward side effects as a result of the failure to follow procedures for the accounting of controlled substances. Both residents received their medications as prescribed.</p> <p>2. All residents have the potential to be effected by not following proper procedures for the accounting of controlled substances. Nurses #11,#12, and #15 were instructed on the proper procedures for accounting of controlled substances by the Clinical Educator on 9/3/15, 9/22/15, and 9/9/15 respectively.</p> <p>3. Nurses #11,#12, and #15 along with all other nurses will be inserviced by 10/1/15 by the Clinical Educator on the facility's policy and procedure for Medication</p> | | |

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| F 431 | <p>Continued From page 66</p> <p>Resident #252 on the following date: --On 8/5/15, nurse ' s initials were placed on the front of the MAR to designate the date the medication was administered to the resident; the back of the MAR included a note dated 8/5/15 at 2:30 PM to indicate 5 mg of oxycodone was given for pain.</p> <p>A review of the resident ' s Controlled Drug Record (a declining inventory record which is also referred to as a Narcotic Sheet) for oxycodone revealed 5 mg of oxycodone was taken from the inventory for Resident #252 six times during the month of August 2015 on the following dates/times: --8/5/15 at 2:15 PM --8/5/15 at 6:15 PM --8/5/15 at 10:30 PM --8/19/15 at 2:00 PM --8/26/15 at 1:00 PM --8/28/15 at 1:30 PM</p> <p>An interview was conducted on 9/2/2015 at 10:27 AM Nurse #11. Nurse #11 was the D Wing 1st shift nurse assigned to care for Resident #252. Upon request, the nurse discussed the process employed for the administration/documentation of as needed (PRN) narcotic medications to a resident. Nurse #11 stated a resident would be assessed and then the physician orders and the dates/times of prior receipt of the medications would be reviewed. The nurse indicated the medication would be pulled from the medication cart and documented as having been pulled on the resident ' s Controlled Drug Record. After the medication was given to the resident, its administration would then be noted on both the front and back of the MAR.</p> | F 431 | <p>Administration to include the proper procedure for documenting the administration of a controlled substance medication on the medication administration record (MAR) and Controlled Drug Record. The DON/Clinical Manager/RN Team Leader will audit 5 MAR's and 5 Controlled Drug Records per hall via the new "Narcotic Documentation Audit" tool daily for one week, then twice a week for eight weeks to ensure controlled substance administration is documented on the MAR and controlled drug record per policy and procedure. Any discrepancies will be corrected at that time via one to one inservice education.</p> <p>4. The facility's QAPI Committee will review the results of the Narcotic Documentation Audit tools in the monthly QAPI Committee meeting to monitor for compliance for three months. The consultant pharmacist will also monitor for compliance for three months during his monthly consultant visits utilizing the monthly consultant pharmacy report and notify the DON/Administrator of his findings during monthly exit meetings.</p> | | |

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| F 431 | <p>Continued From page 67</p> <p>An interview was conducted on 9/2/2015 at 11:20 AM with the facility ' s Director of Nursing (DON). Upon review of Resident #252 ' s Controlled Drug/Record and MAR, the DON acknowledged there were inconsistencies between the two records. Upon inquiry, the DON outlined the facility ' s procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the Controlled Drug Record and the resident ' s MAR. The DON indicated the documentation for the medication administration was primarily required on the front of the MAR, although it was preferable to also include a notation of this administration on the back of the MAR as well. The DON identified the nurses who pulled/administered the resident ' s medication by his/her signature on the Controlled Drug Record and MAR.</p> <p>A follow-up interview was conducted on 9/2/2015 at 11:55 AM with Nurse #11 in the presence of the DON. Nurse #11 was the nurse identified as administering Resident #252 ' s oxycodone on 8/5/15 at 2:30 PM. This nurse was also identified as documenting Resident #252 ' s oxycodone was pulled on the Controlled Drug Record without documenting its administration to the resident on the MAR (on 8/19/15 at 2:00 PM, on 8/26/15 at 1:00 PM, and on 8/28/15 at 1:30 PM). During the interview, the DON inquired if Nurse #11 recalled giving the oxycodone to Resident #252. The nurse stated she did. However, Nurse #11 indicated she did not know why the medication administration was not documented on Resident #252 ' s MAR. She stated all doses of the medication should have been documented as given on the front and back of the MAR.</p> | F 431 | | | |

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| F 431 | <p>Continued From page 68</p> <p>A telephone interview was conducted on 9/2/15 at 1:34 PM with the facility ' s Consultant Pharmacist. Upon inquiry, the pharmacist stated he expected documentation of a controlled substance medication to be completed on the Controlled Drug Record when the medication was taken from the medication cart for the resident. He indicated it was also expected for the nurse to sign on the resident ' s MAR after the medication was administered to the resident, indicating the date the medication was given.</p> <p>1b) Resident #252 was admitted to the facility on 8/27/14. A review of Resident #252 ' s current medication orders included the following: 0.5 milligrams (mg) lorazepam (an antianxiety medication) given as one tablet by mouth every 6 hours as needed for anxiety. Lorazepam is a controlled substance medication.</p> <p>A review of Resident #252 ' s August 2015 Medication Administration Record (MAR) indicated lorazepam was administered to Resident #252 on the following dates: --On 8/1/15, nurse ' s initials were placed on the front of the MAR to designate the date the medication was administered to the resident; the back of the MAR included a note dated 8/1/15 at 1:00 PM to indicate 0.5 mg of lorazepam was given for agitation.</p> <p>A review of the resident ' s Controlled Drug Record (a declining inventory record which is also referred to as a Narcotic Sheet) for lorazepam revealed 0.5 mg of lorazepam was taken from the inventory to be given to Resident #252 three times during the month of August 2015 on the following dates/times:</p> | F 431 | | | |

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| F 431 | <p>Continued From page 69 --8/19/15 at 2:00 PM --8/26/15 at 1:00 PM --8/28/15 at 1:30 PM</p> <p>An interview was conducted on 9/2/2015 at 10:27 AM Nurse #11. Nurse #11 was the D Wing 1st shift nurse assigned to care for Resident #252. Upon request, the nurse discussed the process employed for the administration/documentation of as needed (PRN) narcotic medications to a resident. Nurse #11 stated a resident would be assessed and then the physician orders and the dates/times of prior receipt of the medications would be reviewed. The nurse indicated the medication would be pulled from the medication cart and documented as having been pulled on the resident ' s Controlled Drug Record. After the medication was given to the resident, its administration would then be noted on both the front and back of the MAR.</p> <p>An interview was conducted on 9/2/2015 at 11:20 AM with the facility ' s Director of Nursing (DON). Upon review of Resident #252 ' s Controlled Drug/Record and MAR, the DON acknowledged there were inconsistencies between the two records. Upon inquiry, the DON outlined the facility ' s procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the Controlled Drug Record and the resident ' s MAR. The DON indicated the documentation for the medication administration was primarily required on the front of the MAR, although it was preferable to also include a notation of this administration on the back of the MAR as well. The DON identified the nurses who pulled/administered the resident ' s medication by</p> | F 431 | | | |

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| F 431 | <p>Continued From page 70</p> <p>his/her signature on the Controlled Drug Record and MAR.</p> <p>A follow-up interview was conducted on 9/2/2015 at 11:55 AM with Nurse #11 in the presence of the DON. Nurse #11 was the nurse identified as administering Resident #252 ' s lorazepam on 8/1/15. This nurse was also identified as documenting that Resident #252 ' s lorazepam was pulled from the inventory on the Controlled Drug Record without documenting its administration to the resident on the MAR (on 8/19/15 at 2:00 PM, on 8/26/15 at 1:00 PM, and on 8/28/15 at 1:30 PM). During the interview, the DON inquired if Nurse #11 recalled giving the lorazepam to Resident #252. The nurse stated she did and noted that the resident was particularly anxious on these dates. Nurse #11 indicated she did not know why the medication administration was not documented on Resident #252 ' s MAR. She stated all doses of the medication should have been documented as given on the front and back of the MAR.</p> <p>A telephone interview was conducted on 9/2/15 at 1:34 PM with the facility ' s Consultant Pharmacist. Upon inquiry, the pharmacist stated he expected documentation of a controlled substance medication to be completed on the Controlled Drug Record when the medication was taken from the medication cart for the resident. He indicated it was also expected for the nurse to sign on the resident ' s MAR after the medication was administered to the resident, indicating the date the medication was given.</p> <p>2) Resident #176 was admitted to the facility on 1/21/15. The resident ' s medications included the following: 0.5 milligrams (mg) lorazepam (an</p> | F 431 | | | |

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| F 431 | <p>Continued From page 71</p> <p>antianxiety medication) given as ½ tablet (0.25 mg) by mouth every 6 hours as needed for anxiety (ordered 5/22/15). Lorazepam is a controlled substance medication.</p> <p>A review of Resident #176 ' s August 2015 Medication Administration Record (MAR) indicated lorazepam was administered to Resident #176 on the following dates:</p> <p>--On 8/8/15, a checkmark was placed on the front of the MAR to designate the date the medication was administered to the resident; the back of the MAR included a note dated 8/8/15 to indicate 0.25 mg of lorazepam was given for anxiety. The notation was not timed.</p> <p>--On 8/24/15, a nurse ' s initials were placed on the front of the MAR to indicate lorazepam was administered to Resident #176. No notations were placed on the back of the MAR for this administration.</p> <p>--On 8/25/15, a notation was made only on the back of the MAR to indicate 0.25 mg lorazepam was given to the resident for anxiety.</p> <p>A review of the resident ' s Controlled Drug Record (a declining inventory record which is also referred to as a Narcotic Sheet) for lorazepam revealed 0.25 mg of lorazepam taken from the inventory for Resident #176 nine times during the month of August 2015 on the following dates and times:</p> <p>--8/8/15 at 9:00 AM --8/8/15 at 4:00 PM --8/22/15 at 9:50 PM --8/23/15 at 9:00 AM --8/23/15 at 9:00 PM --8/24/15 at 12:00 PM --8/24/15 at 9:00 PM --8/25/15 at 8:00 AM</p> | F 431 | | | |

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| F 431 | <p>Continued From page 72 --8/25/15 at 8:00 PM</p> <p>An interview was conducted on 9/2/2015 at 10:27 AM Nurse #11. Nurse #11 was the D Wing 1st shift nurse assigned to care for Resident #176. Upon request, the nurse discussed the process employed for the administration/documentation of as needed (PRN) controlled substance medications to a resident. Nurse #11 stated a resident would be assessed and then the physician orders and the dates/times of prior receipt of the medications would be reviewed. The nurse indicated the medication would be pulled from the medication cart and documented as having been pulled on the resident ' s Controlled Drug Record. After the medication was given to the resident, its administration would then be noted on both the front and back of the MAR.</p> <p>An interview was conducted on 9/2/2015 at 11:20 AM with the facility ' s Director of Nursing (DON). Upon review of Resident #176 ' s Controlled Drug/Record and MAR, the DON acknowledged there were inconsistencies between the two records. Upon inquiry, the DON outlined the facility ' s procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the Controlled Drug Record and the resident ' s MAR. The DON indicated the documentation for the medication administration was primarily required on the front of the MAR, although it was preferable to also include a notation of this administration on the back of the MAR as well. The DON identified the nurses who pulled/administered the resident ' s medication(s) by his/her signature on the Controlled Drug</p> | F 431 | | | |

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| F 431 | <p>Continued From page 73 Record and MAR.</p> <p>An interview was conducted on 9/2/2015 at 11:50 AM with Nurse #15 in the presence of the DON. Nurse #15 was the nurse identified as having documented that Resident #176 ' s lorazepam was pulled on the Controlled Drug Record without documenting its administration on the MAR (on 8/22/15 at 9:50 PM and on 8/25/15 at 8:00 PM). During the interview, Nurse #15 reported documentation of the medication administration needed to be completed on the Controlled Drug Record, as well as on the front and back of the MAR. Upon inquiry, the nurse indicated she would have expected the administration of the controlled substance medication to be documented in all 3 places.</p> <p>A follow-up interview was conducted on 9/2/2015 at 11:55 AM with Nurse #11 in the presence of the DON. Nurse #11 was the nurse identified as having documented that Resident #176 ' s lorazepam was pulled on the Controlled Drug Record without documenting its administration on the MAR (on 8/25/15 at 8:00 AM). Nurse #11 indicated she did not know why the medication administration was not documented on Resident #176 ' s MAR. She stated all doses of the medication should have been documented as given on the front and back of the MAR.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:58 PM with Nurse #12. Nurse #12 was the nurse identified as having documented that Resident #176 ' s lorazepam was pulled on the Controlled Drug Record without documenting its administration on the MAR (on 8/8/15 at 9:00 AM, on 8/23/15 at 9:00 AM, and on 8/24/15 at 9:00 PM). During the interview, the nurse indicated</p> | F 431 | | | |

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| F 431 | Continued From page 74 controlled substance medications needed to be documented on the Controlled Drug Record when they were removed for a resident; and, it was required the medication administration to be documented on both the front and back of the resident ' s MAR. When asked about the discrepancies of the documentation with Resident #176 on 8/8/15, 8/23/15 and 8/24/15, the nurse stated, " That must have been a mishap." A telephone interview was conducted on 9/2/15 at 1:34 PM with the facility ' s Consultant Pharmacist. Upon inquiry, the pharmacist stated he expected documentation of a controlled substance medication to be completed on the Controlled Drug Record when the medication was taken from the medication cart for the resident. He indicated it was also expected for the nurse to sign on the resident ' s MAR after the medication was administered to the resident, indicating the date the medication was given. | F 431 | | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective | F 441 | | 10/1/15 | |

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| F 441 | <p>Continued From page 75 actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to follow infection control procedures to prevent the spread of infection during the provision of pressure ulcer wound treatment for 1 of 1 resident (Resident #252) reviewed for wound care. Findings included: Observation was made on 9/02/15 at 9:15 AM of wound treatment provided to Resident #252 's right and left pressure ulcers by the facility treatment nurse. Observation revealed the wound treatment was administered as ordered by the physician. The right outer ankle dressing was removed and the left outer ankle dressing was</p> | F 441 | <p>1. Resident #252 has suffered no untoward side effects from the improper procedures to prevent infection during the observed wound treatment. 2. All residents with wounds are at risk for infection from not following the proper procedures for infection control during wound treatments. The Wound Treatment Nurse was given a one to one inservice by the Clinical Educator on the proper procedures for infection control during wound treatment upon notification by the surveyor of the error. 3. The Wound Treatment Nurse and all</p> | | |

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| F 441 | <p>Continued From page 76</p> <p>removed. The wound was cleansed with normal saline from a newly opened bottle, blotted dry with sterile gauze, Santyl ointment was applied using a cotton tipped applicator (it was noted the cotton tipped applicator was placed back into the medicine cup containing the Santyl ointment), a dated dry gauze dressing was applied securely to cover the right ankle wound. The left ankle was lifted using clean gloved hands. The wound was cleaned with normal saline using sterile gauze and blotted dry using sterile gauze. Santyl ointment was applied using the same cotton applicator swab that had been left in the medicine cup after use on the resident ' s right ankle wound.</p> <p>An interview was conducted on 9/02/15 at 9:25 with the infection control nurse. When it was pointed out to the treatment nurse that she had replaced a contaminated cotton applicator into the Santyl Ointment medicine cup and used the same cotton applicator to apply Santyl Ointment to two separate wounds she responded: " I was nervous. I should have used two separate applicators to apply the Santyl Ointment and I should not have placed the contaminated applicator back into the Santyl ointment medicine cup which was intended to be used on a separate wound. "</p> <p>An interview was conducted on 9/02/5 at 10:30 AM with the Director of Nursing (DON) which revealed her expectation of the treatment nurse is that she provide wound treatment according to nursing practice infection control processes and facility policy for infection control. She stated she was not satisfied with the wound treatment provided by the wound treatment nurse. She further stated that in June, 2015 she had hired a Certified Infection Control nurse to oversee all areas of infection control in the facility.</p> | F 441 | <p>other nurses will be inserviced by the Clinical Educator on the proper procedures for infection control and following aseptic technique when providing wound treatments. New nurses will be inserviced as well. The Clinical Educator will observe the treatment nurse providing one wound treatment per week for four weeks to ensure the proper infection control procedures continue to be followed. The Clinical Educator/RN Team Leader will randomly audit three other nurses providing wound treatments weekly for four weeks to ensure proper infection control procedures are being following during wound treatments. The Clinical Educator/RN Team Leader will utilize the newly created "Dressing Change Competency Audit Tool" for wound treatment audits. The Clinical Educator will reinservice as needed upon findings of improper procedures being followed.</p> <p>4. The facility's QAPI Committee will review the results of the wound treatment audits during the monthly QAPI Committee meetings to monitor for compliance.</p> | | |

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| F 441 | Continued From page 77 An interview was conducted on 9/02/15 at 11:10 AM with the Certified Infection Control Nurse. She stated it was her expectation that the wound treatment nurse provide wound treatment according to professional nursing standards for infection control and the facility policy for infection control. She stated the care that the infection control nurse provided to Resident #252 did not meet these standards. | F 441 | | | |
| F 514 SS=E | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to follow established procedures for the consistent and accurate documentation of the administration of controlled medications on the Medication Administration Records and Controlled Drug Records for 2 of 4 sampled residents (Resident #252, and #176) receiving controlled substances on an as needed basis. | F 514 | 1. Resident's #252 and #176 experienced no untoward side effects as a result of the failure to follow the procedures for the documentation of the controlled substances on the medication administration records and controlled drug records. 2. All residents have the potential to be effected by not following the proper | 10/1/15 | |

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| F 514 | <p>Continued From page 78</p> <p>The findings included:</p> <p>1a) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, Documentation, which read, in part:</p> <p>" Controlled Substances:</p> <p>1. More documentation is required for each dose given - MAR, Declining Inventory sheet, shift count and documentation. "</p> <p>A review of Resident #252 ' s Controlled Drug Record (a declining inventory record which is also known as a Narcotic Log) revealed six doses of 5 milligrams (mg) oxycodone (an opioid pain medication) were removed from the medication cart for Resident #252 during the month of August, 2015. A dose of oxycodone was documented as removed from the med cart for Resident #252 on each of the following dates/times: 8/5/15 at 2:15 PM; 8/5/15 at 6:15 PM; 8/5/15 at 10:30 PM; 8/19/15 at 2:00 PM; 8/26/15 at 1:00 PM; and, 8/28/15 at 1:30 PM.</p> <p>Documentation on Resident #252 ' s August 2015 Medication Administration Record (MAR) indicated 5 mg oxycodone was administered to the resident one time during the month. According to the MAR, a dose of oxycodone was administered to the resident on 8/5/15 at 2:30 PM.</p> <p>An interview was conducted on 9/2/2015 at 10:27 AM Nurse #11. Nurse #11 was the D Wing 1st shift nurse assigned to care for Resident #252. Upon request, the nurse discussed the process employed for the administration/documentation of as needed (PRN) narcotic medications to a</p> | F 514 | <p>procedures for the documentation of the controlled substances on the medication administration records and controlled drug records. Nurses #11,#12, and #15 were instructed on the proper procedures for documentation of the controlled substances on the medication administration records and controlled drug records by the Clinical Educator on 9/3/15, 9/22/15, and 9/9/15 respectively.</p> <p>3. Nurses #11,#12, and #15 along with all other nurses and new hire nurses will be inserviced by the Clinical Educator on the facility's policy and procedure for Medication Administration to include the proper procedures for documenting the administration of a controlled substance medication on the medication administration record (MAR) and controlled drug record. All inservices will be completed by 10/1/15. The DON/Clinical Manager/RN Team Leader will conduct a random audit of 5 MAR's and 5 Controlled Drug Records per hall via the new "Narcotic Documentation Audit" tool daily for one week, then twice a week for eight weeks to ensure controlled substance administration is documented on the MAR and controlled drug record per policy and procedure. Any discrepancies will be corrected at that time via one to one inservice education.</p> <p>4. The facility's QAPI Committee will review the results of the Narcotic Documentation Audit tools in the monthly QAPI Committee meeting to monitor for compliance for three months. The consultant pharmacist will also monitor for compliance for three months during his</p> | | |

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| F 514 | <p>Continued From page 79</p> <p>resident. Nurse #11 stated a resident would be assessed and then the physician orders and the dates/times of prior receipt of the medications would be reviewed. The nurse indicated the medication would be pulled from the medication cart and documented as having been pulled on the resident ' s Controlled Drug Record. After the medication was given to the resident, its administration would then be noted on both the front and back of the MAR.</p> <p>An interview was conducted on 9/2/2015 at 11:20 AM with the facility ' s Director of Nursing (DON). Upon review of Resident #252 ' s Controlled Drug/Record and MAR, the DON acknowledged there were inconsistencies between the two records. Upon inquiry, the DON outlined the facility ' s procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the Controlled Drug Record and the resident ' s MAR. The DON indicated the documentation for the medication administration was primarily required on the front of the MAR, although it was preferable to also include a notation of this administration on the back of the MAR as well. The DON identified the nurses who pulled/administered the resident ' s medication by his/her signature on the Controlled Drug Record and MAR.</p> <p>A follow-up interview was conducted on 9/2/2015 at 11:55 AM with Nurse #11 in the presence of the DON. Nurse #11 was the nurse identified as administering Resident #252 ' s oxycodone on 8/5/15 at 2:30 PM. This nurse was also identified as documenting Resident #252 ' s oxycodone was pulled on the Controlled Drug Record without</p> | F 514 | <p>monthly consultant visits utilizing the Monthly Consultant Pharmacist Activity Report and notify the DON/Administrator of his findings during monthly exit meetings.</p> | | |

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| F 514 | <p>Continued From page 80</p> <p>documenting its administration to the resident on the MAR (on 8/19/15 at 2:00 PM, on 8/26/15 at 1:00 PM, and on 8/28/15 at 1:30 PM). During the interview, the DON inquired if Nurse #11 recalled giving the oxycodone to Resident #252. The nurse stated she did. However, Nurse #11 indicated she did not know why the medication administration was not documented on Resident #252 ' s MAR. She stated all doses of the medication should have been documented as given on the front and back of the MAR.</p> <p>A telephone interview was conducted on 9/2/15 at 1:34 PM with the facility ' s Consultant Pharmacist. Upon inquiry, the pharmacist stated he expected documentation of a controlled substance medication to be completed on the Controlled Drug Record when the medication was taken from the medication cart for the resident. He indicated it was also expected for the nurse to sign on the resident ' s MAR after the medication was administered to the resident, indicating the date the medication was given.</p> <p>1b) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, Documentation, which read, in part: " Controlled Substances: 1. More documentation is required for each dose given - MAR, Declining Inventory sheet, shift count and documentation. "</p> <p>A review of Resident #252 ' s Controlled Drug Record (a declining inventory record which is also known as a Narcotic Log) revealed three doses of 0.5 milligrams (mg) lorazepam (an antianxiety medication) were removed from the medication cart for Resident #252 during the month of</p> | F 514 | | | |

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| F 514 | <p>Continued From page 81</p> <p>August, 2015 on each of the following dates/times: 8/19/15 at 2:00 PM; 8/26/15 at 1:00 PM; and, 8/28/15 at 1:30 PM.</p> <p>Documentation on Resident #252 ' s August 2015 Medication Administration Record (MAR) indicated 0.5 mg lorazepam was administered to the resident one time during the month. According to the MAR, a dose of lorazepam was administered to the resident on 8/1/15 at 1:00 PM.</p> <p>An interview was conducted on 9/2/2015 at 10:27 AM Nurse #11. Nurse #11 was the D Wing 1st shift nurse assigned to care for Resident #252. Upon request, the nurse discussed the process employed for the administration/documentation of as needed (PRN) narcotic medications to a resident. Nurse #11 stated a resident would be assessed and then the physician orders and the dates/times of prior receipt of the medications would be reviewed. The nurse indicated the medication would be pulled from the medication cart and documented as having been pulled on the resident ' s Controlled Drug Record. After the medication was given to the resident, its administration would then be noted on both the front and back of the MAR.</p> <p>An interview was conducted on 9/2/2015 at 11:20 AM with the facility ' s Director of Nursing (DON). Upon review of Resident #252 ' s Controlled Drug/Record and MAR, the DON acknowledged there were inconsistencies between the two records. Upon inquiry, the DON outlined the facility ' s procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on</p> | F 514 | | | |

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| F 514 | <p>Continued From page 82</p> <p>both the Controlled Drug Record and the resident ' s MAR. The DON indicated the documentation for the medication administration was primarily required on the front of the MAR, although it was preferable to also include a notation of this administration on the back of the MAR as well. The DON identified the nurses who pulled/administered the resident ' s medication by his/her signature on the Controlled Drug Record and MAR.</p> <p>A follow-up interview was conducted on 9/2/2015 at 11:55 AM with Nurse #11 in the presence of the DON. Nurse #11 was the nurse identified as administering Resident #252 ' s lorazepam on 8/1/15. This nurse was also identified as documenting that Resident #252 ' s lorazepam was pulled on the Controlled Drug Record without documenting its administration to the resident on the MAR (on 8/19/15 at 2:00 PM, on 8/26/15 at 1:00 PM, and on 8/28/15 at 1:30 PM). During the interview, the DON inquired if Nurse #11 recalled giving the lorazepam to Resident #252. The nurse stated she did and noted that the resident was particularly anxious on these dates. Nurse #11 indicated she did not know why the medication administration was not documented on Resident #252 ' s MAR. She stated all doses of the medication should have been documented as given on the front and back of the MAR.</p> <p>A telephone interview was conducted on 9/2/15 at 1:34 PM with the facility ' s Consultant Pharmacist. Upon inquiry, the pharmacist stated he expected documentation of a controlled substance medication to be completed on the Controlled Drug Record when the medication was taken from the medication cart for the resident. He indicated it was also expected for the nurse to</p> | F 514 | | | |

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| F 514 | <p>Continued From page 83</p> <p>sign on the resident ' s MAR after the medication was administered to the resident, indicating the date the medication was given.</p> <p>2) A review of the facility ' s policy on " Medication Administration Guidelines " (revised January 2013) included a section titled, Documentation, which read, in part: " Controlled Substances: 1. More documentation is required for each dose given - MAR, Declining Inventory sheet, shift count and documentation. "</p> <p>A review of Resident #176 ' s Controlled Drug Record (a declining inventory record which is also known as a Narcotic Log) revealed nine doses of 0.25 milligrams (mg) lorazepam (an antianxiety medication) were removed from the medication (med) cart for Resident #176 during the month of August, 2015 on each of the following dates/times: 8/8/15 at 9:00 AM; 8/8/15 at 4:00 PM; 8/22/15 at 9:50 PM; 8/23/15 at 9:00 AM; 8/23/15 at 9:00 PM; 8/24/15 at 12:00 PM; 8/24/15 at 9:00 PM; 8/25/15 at 8:00 AM; and, 8/25/15 at 8:00 PM.</p> <p>Documentation on Resident #176 ' s August 2015 Medication Administration Record (MAR) indicated 0.25 mg lorazepam was administered to the resident three times during the month. According to the MAR, a dose of lorazepam was administered to the resident on 8/8/15 (the notation was not timed); 8/24/15 (the notation was not timed); and, 8/25/15 (a notation was made on the back of the MAR only).</p> <p>An interview was conducted on 9/2/2015 at 10:27 AM Nurse #11. Nurse #11 was the D Wing 1st shift nurse assigned to care for Resident #176.</p> | F 514 | | | |

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| F 514 | <p>Continued From page 84</p> <p>Upon request, the nurse discussed the process employed for the administration/documentation of as needed (PRN) narcotic medications to a resident. Nurse #11 stated a resident would be assessed and then the physician orders and the dates/times of prior receipt of the medications would be reviewed. The nurse indicated the medication would be pulled from the medication cart and documented as having been pulled on the resident ' s Controlled Drug Record. After the medication was given to the resident, its administration would then be noted on both the front and back of the MAR.</p> <p>An interview was conducted on 9/2/2015 at 11:20 AM with the facility ' s Director of Nursing (DON). Upon review of Resident #176 ' s Controlled Drug/Record and MAR, the DON acknowledged there were inconsistencies between the two records. Upon inquiry, the DON outlined the facility ' s procedures for documenting the administration of a controlled substance medication to a resident. The DON reported she would expect documentation to be completed on both the Controlled Drug Record and the resident ' s MAR. The DON indicated the documentation for the medication administration was primarily required on the front of the MAR, although it was preferable to also include a notation of this administration on the back of the MAR as well. The DON identified the nurses who pulled/administered the resident ' s medication by his/her signature on the Controlled Drug Record and MAR.</p> <p>An interview was conducted on 9/2/2015 at 11:50 AM with Nurse #15 in the presence of the DON. Nurse #15 was the nurse identified as having documented that Resident #176 ' s lorazepam</p> | F 514 | | | |

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| F 514 | <p>Continued From page 85</p> <p>was pulled on the Controlled Drug Record without documenting its administration on the MAR (on 8/22/15 at 9:50 PM and on 8/25/15 at 8:00 PM). Nurse #15 reported documentation of the medication administration needed to be completed on the Controlled Drug Record, as well as on the front and back of the MAR. Upon inquiry, the nurse indicated she would have expected the administration of the controlled substance medication to be documented in all 3 places.</p> <p>A follow-up interview was conducted on 9/2/2015 at 11:55 AM with Nurse #11 in the presence of the DON. Nurse #11 was the nurse identified as having documented that Resident #176 ' s lorazepam was pulled on the Controlled Drug Record without documenting its administration on the MAR (on 8/25/15 at 8:00 AM). Nurse #11 indicated she did not know why the medication administration was not documented on Resident #176 ' s MAR. She stated all doses of the medication should have been documented as given on the front and back of the MAR.</p> <p>A telephone interview was conducted on 9/2/2015 at 1:58 PM with Nurse #12. Nurse #12 was the nurse identified as having documented that Resident #176 ' s lorazepam was pulled on the Controlled Drug Record without documenting its administration on the MAR (on 8/8/15 at 9:00 AM, on 8/23/15 at 9:00 AM, and on 8/24/15 at 9:00 PM). During the interview, the nurse indicated narcotic medications needed to be documented on the Controlled Drug Record when they were removed for a resident; and, it was required the medication administration be documented on both the front and back of the resident ' s MAR. When asked about the discrepancies of the</p> | F 514 | | | |

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| F 514 | Continued From page 86 documentation with Resident #176 ' s lorazepam on 8/8/15, 8/23/15 and 8/24/15, the nurse stated, " That must have been a mishap." A telephone interview was conducted on 9/2/15 at 1:34 PM with the facility ' s Consultant Pharmacist. Upon inquiry, the pharmacist stated he expected documentation of a controlled substance medication to be completed on the Controlled Drug Record when the medication was taken from the medication cart for the resident. He indicated it was also expected for the nurse to sign on the resident ' s MAR after the medication was administered to the resident, indicating the date the medication was given. | F 514 | | | |