STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. BUILDING _____ B. WING _____	C 05/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - STARMOUNT	109 S HOLDEN ROAD GREENSBORO, NC 27407

(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 The 2567 was amended on 06/03/16 to add tag F282 and make corrections to the tag F323.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow care plan interventions for 1 of 1 resident (Resident #1) assessed as a falls risk. This resulted in a fall which caused a left femur (thigh bone) fracture that required an open reduction internal fixation (ORIF) surgical procedure to correct, and 2 more subsequent falls without a reported injury. Findings included: Resident #1 was admitted to the facility on 12/15/15. Cumulative diagnoses included dementia, Alzheimer's disease, a history of falling, osteoporosis, and protein calorie malnutrition. A review of a nursing note dated 12/31/15 at 7:55 PM read, in part, "Admitted from home with family present. Resident ambulatory with slightly unsteady gait, alert and oriented to family with periods of confusion. Will require supervision when ambulating due to unsteady gait at times." A review of a nursing note dated 1/1/16 at 7:23 PM read, in part, "Resident was noted to be wandering down hallway with unsteady gait." The note further indicated the resident was redirected	F 282	Preparation and/or execution of this plan of correction does not constitute the admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. 1. A falls risk assessment of the resident was completed by a licensed nurse on 5/6/16. The comprehensive care plan for this resident was reviewed and updated to reflect the current therapy and nursing recommendations on 5/5/16. The bed mat was placed at the bedside of the affected resident on 5/5/16. 2. All current residents have the potential to be affected. The plan of care for residents deemed at falls risk will be reviewed and revised as necessary by the Resident Assessment Coordinator/or	6/17/16

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

Electronically Signed | 05/26/2016

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F 282	Continued From page 1 and encouraged to use the walker, but the resident was non-compliant due to mental status. A review of the admission Minimum Data Set (MDS) dated 1/8/16 revealed Resident #1 had no vision, speech or hearing deficits, was severely cognitively impaired, displayed inattention and disorganized thinking constantly, wandering-with significant risk to the resident occurred daily, and had no limb impairment. All activities of daily living (ADLs) required supervision except dressing which required extensive assistance. Resident #1 was unable to perform transitions and walking without staff assistance related to (r/t) not being steady without assistance. Active diagnoses included Alzheimer's disease, depression, and chronic obstructive pulmonary disease (COPD). A review of the physical therapy (PT) notes revealed Resident #1 received PT beginning on 1/1/16 and therapy ended on 1/14/16. A note dated 2/3/16 revealed Resident #1 was discharged from PT on 1/14/16 r/t "Goal met." The PT note indicated the resident needed stand by assistance (SBA)/supervision for safe transfers, sit to stand and stand pivot due to the resident's impaired cognition and subsequent poor safety awareness. The clinical impression entered by PT #1 read, "Nursing staff have been educated in patient assist (assistance) level for transfers and ambulation(walking)-including (the) need for CGA (contact guard assistance-actually touching the resident) with ambulation, hand held assistance and need for SBA for transfers-and high fall risk." A review of the care plans dated 1/20/16 included a care plan r/t "Impaired neurological status r/t Alzheimer's disease." The goal was to be free from injury. Interventions included assistance in mobility as needed. An additional care plan dated	F 282	designee. Any identified issues will be corrected immediately. 3. Education will be provided to the Nursing Staff and Therapy Staff will be completed by the Director of Nursing Services/or designee on the falls assessment, the care plan accuracy, and the implementation of the interventions as well as communication from the Skilled Therapy Staff on recommendations for fall management. 4. Director of Nursing Services/or designee will review any new skilled therapy recommendations/communications for fall management five times weekly during the Clinical Start Up Meeting. The Director of Nursing Services/or designee will review ten residents weekly for three months to ensure fall interventions are implemented. Any issues identified will be corrected and inservice education provided. The results of the monitoring will be reviewed at the monthly Quality Assurance and Performance Improvement Meeting monthly times three months for additional recommendations as identified.	

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F 282	Continued From page 2	F 282		

1/20/16 was present r/t a physical functioning deficit r/t a mobility impairment. Interventions included assistive devices as needed, locomotion assistance as needed, and walking assistance as needed. A care plan for falls r/t use of medications, a new environment and no safety awareness dated 1/20/16 was initiated and revealed a goal of no falls through the next review. The interventions listed were: call light or personal items (to be) available and in easy reach; keep (the) environment well lit and free of clutter; and observe for side effects of medications.

A nursing note dated 2/4/16 at 7:27 PM read, in part, "6 PM, during dinner, 2 staff members heard the resident fall on the floor on her right side, when staff approached the resident to assess for injuries the resident rolled over onto her left side and became physically aggressive with the nurse. Unit manager was called to the unit to assist with assessing the resident and the resident began to scream at the staff stating, 'Don't touch me my leg hurts.' Resident remains on the floor. Unable to assess ROM (range of motion). 6:10 PM- 911 was called by the unit manager. 6:15 PM- Resident's family members were called and message was left for both to call facility. 6:15 PM- the Director of Nursing (DON) responded to the dining room attempting to convince the resident to allow the staff to assist her off the floor. Resident remains resistant and continues to scream and yell at staff. The nursing note further indicated: 6:30 PM- Resident's family member returned call. Informed regarding fall. 7:00 PM- 911 called a second time. 7:10 PM- resident's family member arrived at the facility and was able to calm the resident down. 7:20 PM- EMS (Emergency Medical Services) arrived and resident out to (hospital name) ER

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(Emergency Room) for evaluation and treatment."
A review of the hospital radiology report dated 2/4/16 revealed Resident #1 sustained a left femur (thigh bone) fracture with displacement and angulation. There was no evidence of significant degenerative changes.
The care plan r/t falls was revised on 2/11/16. The goal was modified to reduce the number of falls through the next review. Interventions were modified to include footwear to prevent slipping as needed, monitor the resident frequently and keep in a highly visible area, a therapy referral per physician order, toilet schedule as needed, and transferred to the hospital-upon return will place low impact mattress to floor and therapy referral.
An observation made on 5/4/16 at 8:00 AM of Resident #1's room revealed no low impact mattress (fall mat) at Resident #1's bedside.
An additional observation was made on 5/4/16 at 11:00 AM of Resident #1's room and revealed no fall mat present.
An observation was made on 5/4/16 at 11:40 AM of Resident #1's room with the Administrator, and Director of Nursing (DON). The resident was lying supine in the bed with no fall mat present. The DON stated, "There should be a fall mat there."
A nursing note dated 3/11/16 at 4:55 PM was labeled "Late entry" and read, "Resident (Resident #1) attempted self-transfer. Found on floor at bedside after lunch. Staff re-educated to provide rest periods after each meal, and continue to keep in highly visible area."
An interview with the DON on 5/4/16 at 11:40 AM revealed Resident #1 had a fall on 3/11/16. She stated, "The staff left her in her room (Resident #1) in her geri-chair unsupervised and she had a fall while trying to transfer herself."
Care plans were again revised on 3/18/16. Goals

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were modified and read no falls through the next review. Interventions were modified and included staff (were) re-educated to provide rest periods after each meal and place (the resident) in a highly visible area.
A nursing note dated 5/3/16 at 2:59 AM revealed Resident #1 had made "several" attempts to get out of bed, with her legs hanging over the assist rail of the bed. Repositioning was attempted but was not successful. Resident #1 was placed in a Geri-chair.
A nursing note dated 5/4/16 at 5:00 PM read, "Observed on floor by staff. History of falls, altered safety awareness, Alzheimer's disease."
A nursing note dated 5/4/16 at 7:08 PM read, "Observed with legs hanging over assist rails attempting to get OOB (out of bed). Resident placed in Geri-chair by staff to promote safety. Placed in hallway. Constant viewing of resident performed by all staff members. At 8:10 PM resident placed in bed."
An interview with the Director of Nursing (DON) was conducted on 5/5/16 at 10:30 AM r/t a fall Resident #1 had on 5/4/16 at 5:00 PM. She stated her understanding was NA #2 saw the resident's (Resident #1) feet under the curtain in her room. When NA #2 entered she saw the resident sitting on the fall mat on the floor with her back against the assist rail.
An interview with NA #3 was conducted on 5/5/16 at 10:55 AM. She stated, "The call light was going off for the resident (Resident #1). I went down to the room and the nurse was already in there. She asked me for help because the resident had both legs hanging over the bed between the assist rail and foot board."
An interview with NA #2 was conducted on 5/5/16 at 3:10 PM. She stated, "She (Resident #1) had a fall out of bed yesterday. I was walking up the

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F 282	Continued From page 5 hall and saw her feet under the curtain. I looked behind it and she was sitting on the floor. I went to her nurse (Nurse #8) and told her she (Resident #1) had fallen, she said okay and continued to pass her medications in other resident rooms." Nurse #8 was not available to be interviewed.	F 282		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to provide therapy recommended assistance for 1 of 3 residents (Resident #1) that were assessed as being a high risk for falls. The resident had a fall which resulted in a fractured left hip. Findings included: Resident #1 was admitted to the facility on 12/15/15. Cumulative diagnoses included dementia, Alzheimer's disease, a history of falling, osteoporosis, and protein calorie malnutrition. A review of a nursing note dated 12/31/15 at 7:55 PM read, in part, "Admitted from home with family present. Resident ambulatory with slightly unsteady gait, alert and oriented to family with periods of confusion. Will require supervision	F 323	1. A falls risk assessment of the resident was completed by a licensed nurse on 5/6/16. The comprehensive care plan for this resident was reviewed and updated to reflect the current therapy and nursing recommendations on 5/5/16. The bed mat was placed at the bedside of the affected resident on 5/5/16. 2. All current residents have the potential to be affected. The plan of care for residents deemed at falls risk will be reviewed and revised as necessary by the Resident Assessment Coordinator/or designee. Any identified issues will be corrected immediately.	6/17/16

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F 323	Continued From page 6 when ambulating due to unsteady gait at times." A review of a nursing note dated 1/1/16 at 7:23 PM read, in part, "Resident was noted to be wandering down hallway with unsteady gait." The note further indicated the resident was redirected and encouraged to use the walker, but the resident was non-compliant due to mental status. A review of the nursing notes dated 1/8/16, 1/9/16, 1/10/16, and 1/11/16 revealed Resident #1 had 1 to 1 (1:1) observation for wandering behavior. No further entries related to (r/t) 1:1 observation after 1/11/16. A review of the admission Minimum Data Set (MDS) dated 1/8/16 revealed Resident #1 had no vision, speech or hearing deficits, was severely cognitively impaired, displayed inattention and disorganized thinking constantly, wandering-with significant risk to the resident occurred daily, and had no limb impairment. All activities of daily living (ADLs) required supervision except dressing which required extensive assistance. Resident #1 was unable to perform transitions and walking without staff assistance related to (r/t) not being steady without assistance. Active diagnoses included Alzheimer's disease, depression, and chronic obstructive pulmonary disease (COPD). A review of the physical therapy (PT) notes revealed Resident #1 received PT beginning on 1/1/16 and therapy ended on 1/14/16. A note dated 2/3/16 revealed Resident #1 was discharged from PT on 1/14/16 r/t "Goal met." The PT note indicated the resident needed stand by assistance (SBA)/supervision for safe transfers, sit to stand and stand pivot due to the resident's impaired cognition and subsequent poor safety awareness. The clinical impression entered by PT #1 read, "Nursing staff have been educated in patient assist (assistance) level for	F 323	3. Education will be provided to the Nursing Staff and Therapy Staff will be completed by the Director of Nursing Services/or designee on the falls assessment, the care plan accuracy, and the implementation of the interventions as well as communication from the Skilled Therapy Staff on recommendations for fall management. 4. Director of Nursing Services/or designee will review any new skilled therapy recommendations/communications for fall management five times weekly during the Clinical Start Up Meeting. The Director of Nursing Services/or designee will review ten residents weekly for three months to ensure fall interventions are implemented. Any issues identified will be corrected and inservice education provided. The results of the monitoring will be reviewed at the monthly Quality Assurance and Performance Improvement Meeting monthly times three months for additional recommendations as identified.	

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transfers and ambulation(walking)-including (the) need for CGA (contact guard assistance-actually touching the resident) with ambulation, hand held assistance and need for SBA for transfers-and high fall risk."
A review of the care plans dated 1/20/16 included a care plan r/t "Impaired neurological status r/t Alzheimer's disease." The goal was to be free from injury. Interventions included assistance in mobility as needed. An additional care plan dated 1/20/16 was present r/t a physical functioning deficit r/t a mobility impairment. Interventions included assistive devices as needed, locomotion assistance as needed, and walking assistance as needed. A care plan for falls r/t a new environment and no safety awareness dated 1/20/16 was implemented and revealed a goal of no falls through the next review. The interventions listed were: call light or personal items (to be) available and in easy reach; keep (the) environment well lit and free of clutter; and observe for side effects of medications.
A progress note dated 2/4/16 and timed 5:14 PM read, "Social Services spoke to RP (Responsible Party) to inform her about the resident's (Resident #1) wandering behavior. The resident will be placed on one to one (1:1)."
A review of the staffing sheets dated 2/4/16 revealed no entries for 1:1 assignment r/t Resident #1.
A nursing note dated 2/4/16 at 7:27 PM read, in part, "6 PM, during dinner, 2 staff members heard the resident fall on the floor on her right side, when staff approached the resident to assess for injuries the resident rolled over onto her left side and became physically aggressive with the nurse. Unit manager was called to the unit to assist with assessing the resident and the resident began to scream at the staff stating,

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'Don't touch me my leg hurts.' Resident remains on the floor. Unable to assess ROM (range of motion). 6:10 PM- 911 was called by the unit manager. 6:15 PM- Resident's family members were called and message was left for both to call facility. 6:15 PM- the Director of Nursing (DON) responded to the dining room attempting to convince the resident to allow the staff to assist her off the floor. Resident remains resistant and continues to scream and yell at staff. The nursing note further indicated: 6:30 PM- Resident's family member returned call. Informed regarding fall. 7:00 PM- 911 called a second time. 7:10 PM- resident's family member arrived at the facility and was able to calm the resident down. 7:20 PM- EMS (Emergency Medical Services) arrived and resident out to (hospital name) ER (Emergency Room) for evaluation and treatment."
A review of the hospital radiology report dated 2/4/16 revealed Resident #1 sustained a left femur (thigh bone) fracture with displacement and angulation. There was no evidence of significant degenerative changes.
An interview was conducted with nursing assistant #1 (NA) on 5/5/16 t 3:55 PM. She stated she was assigned to the dining room on 2/4/16 when Resident #1 fell. She also stated, "I was helping another resident and I heard (Resident #1) yell out, 'Help, help.' When I turned around she was on the floor. She required supervision because she walked around herself. She was 1:1 at the time, but I wasn't assigned to her. The DON will have us do 1:1 for some residents and that means you care for that specific resident only. The DON assigned someone to be 1:1 with (Resident #1) that night because of her Alzheimer's, but it wasn't me."
An interview was conducted with Nurse #4 on 5/5/16 at 4:05 PM. She stated she was assigned

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to the hall where Resident #1 resided on 2/4/16 and Resident #1 was 1:1 at that time. She also stated a NA assigned 1:1 with a resident was to stay with the resident they were assigned to only. She could not state who was assigned to Resident #1 on 2/4/16.

A nursing note dated 2/5/16 labeled "Late entry" read, "Falls Management Meeting: Resident (Resident #1) noted with increased agitation with restlessness and exit seeking behavior requiring 1:1 care. Noted (on 2/4/16) ambulating in (the) dining room reorganizing table cloths prior to staff hearing resident scream. Resident transferred to the hospital. Upon return to the facility will place low impact mattress (falls mat) and therapy referral."

The care plans were updated on 2/11/16. Goals were modified to reduce the number of falls through the next review. Interventions were modified to include: footwear to prevent slipping as needed, monitor the resident frequently and keep in a highly visible area, a therapy referral per physician order, toilet schedule as needed, and transferred to the hospital-upon return will place low impact mattress to floor and therapy referral.

A nursing note dated 3/11/16 at 4:55 PM was labeled "Late entry" and read, "Resident (Resident #1) attempted self-transfer. Found on floor at bedside after lunch. Staff re-educated to provide rest periods after each meal, and continue to keep in highly visible area."

Care plans were revised on 3/18/16. Goals were modified to no falls through the next review. Interventions were modified and included: keep the resident in a highly visible area, and re-educate (staff) to provide rest periods after each meal.

A nursing note dated 5/3/16 at 2:59 AM revealed

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Resident #1 had made "several" attempts to get out of bed, with her legs hanging over the assist rail of the bed. Repositioning was attempted but was not successful. Resident #1 was placed in a Geri-chair.
A nursing note dated 5/4/16 at 5:00 PM read, "Observed on floor by staff. History of falls, altered safety awareness, Alzheimer's disease."
A nursing note dated 5/4/16 at 7:08 PM read, " Observed with legs hanging over assist rails attempting to get OOB (out of bed). Resident placed in Geri-chair by staff to promote safety. Placed in hallway. Constant viewing of resident performed by all staff members. At 8:10 PM resident placed in bed. "
An interview with NA #2 was conducted on 5/5/16 at 3:10 PM. She stated, "She (Resident #1) had a fall out of bed yesterday. I was walking up the hall and saw her feet under the curtain. I looked behind it and she was sitting on the floor. I went to her nurse (Nurse #8) and told she had fallen, she said okay and continued to pass her medications in other resident rooms. "
Nurse #8 was not available to be interviewed.
An interview with the Director of Nursing (DON) was conducted on 5/5/16 at 10:30 AM r/t a fall Resident #1 had on 5/4/16 at 5:00 PM. She stated her understanding was NA #2 saw the resident's (Resident #1) feet under the curtain in her room. When NA #2 entered she saw the resident sitting on the fall mat on the floor with her back against the assist rail.
An interview with NA #3 was conducted on 5/5/16 at 10:55 AM. She stated, " The call light was going off for the resident (Resident #1). I went down to the room and the nurse was already in there. She asked me for help because the resident had both legs hanging over the bed between the assist rail and foot board. "

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An interview with the rehabilitation director was conducted on 5/5/16 at 12:25 PM. She stated stand by assistance (SBA) meant someone was standing beside the resident to give assistance if needed. There was no physical contact with the resident unless the resident was going to lose their balance or possibly fall. She stated Resident #1 needed varying levels of assistance from day to day. Recommendations were made to the medical staff and resident, if the resident was able to understand, r/t assistance needs. She stated the cognitive level of Resident #1 did not allow for education because, " She couldn't remember what we talked about. So we educated the nurses."

An interview was conducted on 5/6/16 at 10:10 AM with Physical Therapist (PT) #1. She stated, " In my opinion she was never not a high risk for falls. PT recommended a level of contact guard assistance (CGA) which is more hands on than SBA. It was a difficult therapy with (Resident #1) because it's hard to convince someone with her cognitive deficits (to follow directions). She required more encouragement and was easily distracted, and she did benefit from increased observation, or 1 to 1 observation as it's sometimes called. "

An interview with Nurse #3 was conducted on 5/4/16 at 10:20 AM. She stated if a NA was assigned a resident for 1:1 observation the NA was to stay with the assigned resident for the length of the shift. If an NA was assigned a resident for 1:1 observation she could not be pulled to any other assignment. She also stated 1:1 assignments were noted on the daily assignment sheets. Nurse #3 said when their assigned resident was in the dining room, the NA assigned to that resident assisted other residents at the same table, but could not walk away from

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F 323	Continued From page 12 their assigned resident. An interview was conducted with the administrator on 5/5/16 at 4:30 PM. She stated, " We utilize 1:1 if needed. If an NA is assigned 1:1 she isn't supposed to be pulled to another assignment. So if an NA is assigned increased supervision (1:1) the NA will finish that shift as 1:1 with that resident. " An additional interview with the administrator was conducted on 5/6/16 at 10:30 AM. The administrator stated, " She (Resident #1) was 1:1 at the time of her fall r/t wandering. All nursing home residents are falls risks. How are we supposed to monitor all of them? I'd love to make everyone 1:1 but that's impossible. She was on increased observation (1:1) for wandering not falls. "	F 323		
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. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		6/17/16

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F 431	Continued From page 13 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. 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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to follow established procedures to provide for an accurate accounting of all controlled medications on 4 of 4 medication carts (1 North, 1 East, 2 North, and 2 East). The findings included: An observation was made of the controlled medication count conducted for the 2 North medication cart upon nursing change of shift on 5/4/16 at 7:15 AM. Nurse #1 was the on-coming nurse and Nurse #2 was the off-going nurse. The two nurses were observed as they counted the number of drug entities stored on the medication cart and compared it to the number of narcotic sheets (a declining inventory) kept in the narcotic book for each of these entities. The number of drug entities and narcotic sheets were in agreement and that number was written on the " Change of Shift Controlled Substances Count	F 431	1. Director of Nursing Services verified all narcotic counts were correct on 5/5/16. A review of all Change of Shift Controlled Substances Count Sheets was completed on 5/6/16 for any trends on all nurse's carts with none noted. No nurse shall work until they understand the policy for narcotic reconciliation at shift change inclusive of documentation required. 2. 100% review of Change of Shift Controlled Substance Count Sheets to identify any issues was completed by the Director of Nursing Services on 5/5/16. 3. All licensed nurses provided education by Director of Nursing Services/or designee on 5/5/16 on the policy for narcotic reconciliation inclusive of the documentation required on the Change of Shift Controlled Substance Sheets to	

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F 431	Continued From page 14 Sheet. " The two nurses were then observed as one nurse counted the individual controlled medications while the other nurse confirmed each count using the corresponding narcotic sheet for that medication. Upon completion of the count, both nurses signed the " Change of Shift Controlled Substances Count Sheet. " An interview was conducted with Nurse #1 and Nurse #2 on 5/4/16 at 7:30 AM. Upon inquiry, the nurses reported when a resident was discharged or deceased, the controlled medications and the corresponding narcotic sheets for that resident were pulled and given to the facility ' s Director of Nursing or charge nurse. They indicated the number of drug entities and narcotic sheets pulled would be noted on the " Change of Shift Controlled Substances Count Sheet " and subtracted from the total count number recorded on this sheet. Review of the facility ' s " Change of Shift Controlled Substances Count Sheet " included a notation written at the top of the form which read, " Note: Signature of nurse arriving on duty and nurse departing from duty indicates that all items (including refrigerated items) are accounted for and that visual verification of placement of Fentanyl patches has been confirmed by both responsible parties. " A review of the " Change of Shift Controlled Substances Count Sheet " for the 1 North medication cart from 4/1/16 to 5/3/16 revealed the following: --Ten (10) nurses ' signatures were missing for the change of shift controlled medication count (1 on 4/2, 1 on 4/3, 1 on 4/5, 1 on 4/6, 2 on 4/12, 1 on 4/14, 2 on 4/17, and 1 on 4/24);	F 431	validate nurse signatures for each shift. 4. Director of Nursing Services/or designee to audit each cart five times a week for a month, three times a week for a month, weekly times a month to validate Change of Shift Controlled Substance Sheets for nurse signatures for each shift change. Audits to also capture each narcotic count is correct for each shift. The results of the monitoring will be reviewed at the facility Quality Assurance and Performance Improvement Meeting monthly times 3 months for additional recommendations as identified.	

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--Six (6) count numbers reflecting the total number of drug entities and narcotic sheets on that cart were missing (1 on 4/5, 1 on 4/6, 1 on 4/8, 1 on 4/9, 1 on 4/12, and 1 on 5/3);
--One (1) removal of a controlled medication and its corresponding narcotic sheet was documented without noting a Resident ' s Name or any other identifying information (1 on 4/3).

A review of the " Change of Shift Controlled Substances Count Sheet " for the 1 East medication cart from 4/1/16 to 5/3/16 revealed the following:
--Six (6) nurses ' signatures were missing for the change of shift controlled medication count (1 on 4/8, 1 on 4/9, 1 on 4/18, 1 on 4/22, 1 on 4/23, and 1 on 5/1);
--Four (4) count numbers reflecting the total number of drug entities and narcotics sheets on that cart were missing (1 on 4/10, 1 on 4/30, and 2 on 5/1);
--Three (3) removals of controlled medications and their corresponding narcotic sheets were documented without noting a Resident ' s Name or any other identifying information (1 on 4/1, 1 on 4/6 and 1 on 4/13);
--Five (5) additions of controlled medications and their corresponding narcotic sheets were documented without noting a Resident ' s Name or any other identifying information (5 on 4/8).
A discrepancy was also noted in the count on the 1 East medication cart between 4/30/16 and 5/2/16. On 4/30/16 the count was documented as 14. Four additions of controlled substance medications/narcotic sheets were noted to have been added on that date. However, the next count recorded on 5/2/16 indicated the total count was 17 (indicating one controlled medication/narcotic sheet was not accounted for).

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No withdrawals from the controlled medications/narcotic sheets had been documented between 4/30/16 and 5/2/16.

A review of the " Change of Shift Controlled Substances Count Sheet " for the 2 North medication cart from 4/1/16 to 5/3/16 revealed the following:
--Seventeen (17) nurses ' signatures were missing for the change of shift controlled medication count (1 on 4/1, 1 on 4/2, 1 on 4/4, 1 on 4/5, 1 on 4/7, 1 on 4/8, 1 on 4/10, 1 on 4/15, 3 on 4/18, 1 on 4/27, 1 on 4/28, 2 on 4/29, 1 on 5/2, 1 on 5/3);
--Eighteen (18) count numbers reflecting the total number of drug entities and narcotics sheets on that cart were missing (1 on 4/8, 2 on 4/9, 2 on 4/15, 1 on 4/16, 1 on 4/18, 1 on 4/19, 2 on 4/22, 2 on 4/24, 2 on 4/25, 1 on 4/30, 2 on 5/1, 1 on 5/2);
--Six (6) removals of controlled medications and their corresponding narcotic sheets were documented without noting a Resident ' s Name or any other identifying information (1 on 4/10, 1 on 4/13, and 4 on 4/27);
--Eighteen (18) additions of controlled medications and their corresponding narcotic sheets were documented without noting a Resident ' s Name or any other identifying information (3 on 4/1, 1 on 4/3, 7 on 4/6, 1 on 4/12, 3 on 4/14, and 3 on 4/26);
--An entire line representing a shift change (including both nurses ' signatures and the count number) were missing on 3 dates (4/12, 4/13, and 4/17).
Additionally, there was a discrepancy in the count numbers of controlled medications/narcotic sheets on the 2 North medication cart from 4/8/16 to 4/10/16. On 4/8/16, the count number was 40. No counts were recorded over the next 3

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(12-hour) nursing shifts. On 4/10, two removals of controlled medications/narcotic sheets were noted. On 4/11/16, the count was noted to be 37 (indicating one controlled medication/narcotic sheet was not accounted for). A second discrepancy was noted in the count on 4/14/16 when the count was recorded as 41. The next count on 4/16/16 was recorded as 39 (indicating two controlled medications/narcotic sheets were not accounted for). There was no documentation of controlled medications/narcotic sheet withdrawal between 4/14/16 and 4/16/16. A third discrepancy was noted in the count between 4/20/16 and 4/21/16. On 4/20/16 the count was documented as 41. One withdrawal of a controlled medication/narcotic sheet was noted on that date. However, the next count noted on 4/21/16 indicated the count was 38 (indicating two controlled medications/narcotic sheets were not accounted for).

A review of the " Change of Shift Controlled Substances Count Sheet " for the 2 East medication cart from 4/1/16 to 5/3/16 revealed the following:
--Six (6) nurses ' signatures were missing for the change of shift controlled medication count (2 on 4/10, 2 on 4/13, 1 on 4/24, and 1 on 4/30);
--Six (6) count numbers reflecting the total number of drug entities and narcotics sheets on that cart were missing (1 on 4/4, 1 on 4/15, 1 on 4/23, 2 on 4/24, and 1 on 4/28);
--Four (4) removals of controlled medications and their corresponding narcotic sheets were documented without noting a Resident ' s Name or any other identifying information (1 on 4/5, 1 on 4/22, and two on 5/3);
--Fourteen (14) additions of controlled medications and their corresponding narcotic

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sheets were documented without noting a Resident ' s Name or any other identifying information (3 on 4/5, 1 on 4/16, 1 on 4/20, 4 on 4/26, 2 on 4/29 and 3 on 5/3).

An interview was conducted on 5/4/16 at 4:02 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reviewed the process for the accounting of controlled medications within the facility. She reported the facility ' s procedures required both the outgoing and oncoming nurses to " count the narcotics (controlled medications), " record the number of drug entities and corresponding narcotic sheets for each entity at shift change, and sign the " Change of Shift Controlled Substances Count Sheet " signifying completion of the task. The DON stated she expected that process to be followed each shift with no exceptions (other than the occurrence of a major disaster). The DON reported when a controlled medication was added to the med cart, the Count Sheet should reflect this addition along with the Resident ' s Name. If a controlled medication and its corresponding narcotic sheet was taken off of the cart, this should also be indicated on the Count Sheet along with the Resident ' s Name. Any controlled medication taken off of the cart was expected to be given to the DON. Upon further inquiry, the DON stated she expected all signature lines on the " Change of Shift Controlled Substances Count Sheet " to be filled out and all counts to be completed, along with additions and subtractions to the count made in accordance with the facility ' s established procedures.

A telephone interview was completed on 5/4/16 at 5:24 PM with the facility ' s Consultant Pharmacist. During the interview, the Consultant

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F 431	Continued From page 19 Pharmacist reviewed the process for the accounting of controlled medications at the facility. Upon inquiry, the pharmacist reported she would expect the nurses to fill out the " Change of Shift Controlled Substances Count Sheet " when medications were put into and taken out of the medication cart; and, she expected two nurses to conduct and sign off on the controlled medication count at the change of each shift.	F 431		