

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

PRINTED: 04/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2017
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NAME OF PROVIDER OR SUPPLIER VILLAGE CARE OF KING	STREET ADDRESS, CITY, STATE, ZIP CODE 440 INGRAM ROAD EXT BOX 1750 KING, NC 27021
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F 157 SS=D	<p>483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment</p>	F 157		3/31/17
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/24/2017
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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 157	<p>Continued From page 1 as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to notify the Physician, the Director of Nursing, and the dialysis center when 1 of 1 sampled resident receiving dialysis treatment and on fluid restrictions (Resident #39) consumed more than 960ml (milliliters) of fluids within a twenty-four hour period.</p> <p>Findings included:</p> <p>Resident #39 was admitted to the facility on 9/19/16 with diagnoses which included: end-stage renal disease, diabetes mellitus, congestive heart failure, fluid overload, and lymphedema.</p> <p>On 11/7/16 the Physician ordered the fluid restriction of 960 ml of fluids every day for Resident #39.</p> <p>Review of the quarterly MDS (minimum data set) dated 12/23/16 indicated Resident #39 was cognitively intact; required limited assistance with eating; had no swallowing problems; weighed 168 pounds; had no weight loss or gain; received a therapeutic diet; and received dialysis treatments. The Care Plan dated 1/3//17 included fluid</p>	F 157	<p>F-157 *Corrective action(s) taken for Rsd# #39</p> <ol style="list-style-type: none"> 1. Rsd# # 39's MD was contacted and made aware of rsdt's non compliance with daily fluid restrictions. New order by MD was given to d/c daily fluid restrictions on 3/3/17. 2. King Dialysis Center was contacted and made aware of rsdt #39's non compliance with daily fluid restrictions. 5 rights of medication administration. <p>*Corrective action(s) taken for residents having potential to be affected by the same practice.</p> <ol style="list-style-type: none"> 1. 100% of all residents currently that have MD orders to have daily fluid 		

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F 157	<p>Continued From page 2</p> <p>restrictions as ordered for the resident.</p> <p>A review of the Meal Card revealed Resident #39 received a regular no added salt, low concentrated sweet diet and was on a 960ml fluid restriction.</p> <p>Review of the Dialysis Center's Note dated 1/13/17 revealed Resident #39 arrived to dialysis center eleven pounds above dry weight. In the past, the nursing home reported that the resident was non-compliant with fluid restriction and was bringing sodas to treatment. The resident's nurse reported that the nursing home did not provide soda and the resident must have asked other residents to get soda from drink machines. It was also documented in the dialysis center's note that the resident's nurse reported that the resident was only restricted to 960ml per shift which was equal to 2880ml per day. The nurse reported that she would discuss with the Director of Nursing on how to further restrict fluids for the resident. The Registered Dietician would encourage the resident to limit fluids between treatments.</p> <p>The review of the Physician's Order dated 1/31/17 revealed Resident #39 was on a 960ml fluid restriction everyday per dialysis.</p> <p>Review of the February 2017 and the March 2017 MARs (Medication Administration Records) revealed Resident #39 frequently received more than 960ml of fluids within a twenty-four hour period.</p> <p>There was no documentation in Resident #39's clinical record and the Dialysis Communication form indicating the Physician, the DON (Director of Nursing) or the Dialysis Center were notified</p>	F 157	<p>restrictions were audited to ensure that no other rsdt was non compliant with MD ordered daily fluid restrictions.</p> <p>*Corrective measures or systemic changes made to ensure that the deficient practice will not occur</p> <p>1. Mandatory in-servicing was provided to all licensed nurses on notifying the MD of rsdt(s) that are non compliant with fluid restrictions.</p> <p>* Indicate how the facility will monitor performance. The DON will be responsible for compliance which is achieved by the DON or alternate designee monitoring for proper notification of MD with non compliance of fluid restrictions two times a week for four weeks and 1 time a week for</p>		

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F 157	<p>Continued From page 3</p> <p>when the resident consumed more than 960ml of fluids in a twenty-four hour period.</p> <p>During an observation and interview on 3/2/17 at 9:02am, Resident #39 revealed she was on fluid restrictions. There was no water pitcher observed in the resident's room.</p> <p>During an interview on 3/2/17 at 11:00am, NA#2 (nursing assistant) indicated the amount of fluids consumed by Resident #39 were recorded and reported to the nurse at end of every shift, every day. NA#2 revealed the resident only received fluids with her meals and one cup of ice each shift with the nurse's permission. She stated that the resident was compliant with her fluid restrictions.</p> <p>During an interview on 3/2/17 at 3:10pm, N#2 (nurse) revealed Resident #39 was compliant with her fluid restrictions; and the amounts of fluids consumed by the resident were documented on the MAR every shift.</p> <p>On 3/3/17 at 10:00am, after reviewing the February and March 2017 MARs, the DON (Director of Nursing) indicated that based on the documentation on the MARs, Resident #39 frequently received more than 960ml of fluids in a twenty-four hour period. The DON stated that it was the responsibility of the Hall Nurse to monitor and report when a resident, who was on fluid restrictions, received more than the fluid restriction allowance. She revealed that the nurse was to report this to the DON, the facility's Physician, and to the Dialysis Center (via the dialysis communication form or telephone), promptly. The DON revealed that she had not received any such notification, but should have.</p>	F 157	<p>eight weeks. QAPI team will review</p> <p>monthly for three months. Completed bu 03/31/2017</p>		

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F 157	Continued From page 4 During a telephone interview on 3/3/17 at 10:13am, the facility's Physician indicated the 960ml fluid restriction for Resident #39 was a goal more than a restriction to ensure the resident's quality of life. He stated that he did not recall, but could have been notified by facility staff of the resident consuming more than 960ml of fluids in a twenty-four hour period; it would not have been something he would have charted. The Physician concluded that because the resident was monitored closely by the dialysis center, he did not consider there to be any significant cause for concern if or when the resident consumed more than 960ml of fluids.	F 157			
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive	F 279		3/31/17	

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F 279	<p>Continued From page 5 care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:</p>	F 279			

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F 279	<p>Continued From page 6</p> <p>Based on record reviews, and staff interview, the facility failed to develop a comprehensive care plan for 1 of 3 sampled residents (Resident #117) reviewed for significant weight loss.</p> <p>Findings included:</p> <p>Resident #117 was admitted to the facility on 12/17/16 with diagnoses which included: right hip joint replacement, diabetes mellitus, and protein-calorie malnutrition.</p> <p>Review of the Admission MDS (minimum data set) dated 12/24/16 indicated Resident #117 was cognitively intact; required supervision with eating; had no swallowing problems; and received a therapeutic diet.</p> <p>The CAA (care area assessment) of the MDS revealed Resident #117's weight was 109 pounds at the time of the assessment; and, required a low concentrated sweets diet of regular texture due to diabetes. The resident also had a diagnosis of protein calorie malnutrition on admission. The documentation in the CAA indicated the facility would care plan the resident for nutrition due to her diagnoses of diabetes and protein-calorie malnutrition.</p> <p>The Weights for Resident #117 since her admission were: Weight on 12/17/16 was 111 lbs. (pounds); Weight at 15 days after Admission (12/30/2016): 101 lbs. (which is 10 lbs. less than at Admission or a 9.0% loss); Weight at 30 days after Admission (01/12/2017): 97 lbs. (which is 14 lbs. less than at Admission or a 12.6% loss).</p>	F 279	<p>F-279 *Corrective action(s) for RsdT #117</p> <p>1. Affected rsdt was discharged prior to identification of issue during survey.</p> <p>No action was needed for rsdt #117.</p> <p>2. CDM was reeducated as to requirement of care plan development for residents with weight loss as per RAI manual.</p> <p>*Corrective action(s) taken for residents having potential to be affected by the same practice.</p> <p>1. Audit of care plans for rsdts with weight loss noted in the past four months was completed to ensure comprehensive care plan is in place.</p> <p>*Corrective measures put in place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>1, CDM will review care plans with each</p>		

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F 279	Continued From page 7 Review of the clinical records revealed on 12/28/16 the Registered Dietician recommended and the Physician ordered Resident #117 was to receive a diabetic house supplement at bedtime. There was no plan of care available with measurable goals and interventions to address the care and treatment related to Resident #117's weight loss, or her diagnoses of diabetes and protein-calorie malnutrition. Review of the medical records revealed Resident #117 was discharged home with home health on 1/17/17 after completing rehabilitative therapy status post hip replacement surgery. During an interview on 3/1/17 at 11:19am, the MDS Coordinator revealed Resident #117's Care Plan was initiated on 12/19/16, reviewed on 12/24/17, and completed on 1/5/17. She acknowledged the resident's Care Plan did not include Nutrition, but it should have.	F 279	MDS assessment and weeklu for rsdts with weight loss. MDS coordinator will complete an audit of all rsdts discussed in weekly weight loss risk meeting to ensure comprehensive care plan is in place. * Indicate how the facility will monitor performance. Weekly log will be maintained by MDS coordinator of rsdts with weight loss and date care plan was initiated. QAPI team will review monthly for three months. Completed by 03/31/2017		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		3/31/17	

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F 281	<p>Continued From page 8</p> <p>by: Based on record reviews and staff interviews, the facility failed to provide the correct narcotic pain medication as ordered by the physician for 1 of 21 residents (Resident #158) reviewed who received a medication borrowed from another resident by the nursing staff.</p> <p>The findings included:</p> <p>Resident #158 was admitted to the facility from the hospital on 2/23/17. The resident ' s cumulative diagnoses included chronic pain and dementia.</p> <p>Resident #158 ' s admission Minimum Data Set (MDS) assessment was not yet due at the time of the review.</p> <p>A review of Resident #158 ' s Physician Orders revealed her admission medications included the following, in part: 5 milligram (mg)/325 mg oxycodone/acetaminophen (a combination opioid medication used for pain management) to be given as one tablet by mouth every 4 hours as needed for pain. Oxycodone/acetaminophen is a controlled substance medication.</p> <p>A review of the Controlled Medication Utilization Record (also known as a narcotic log) for another resident (Resident #39) revealed one tablet of 5/325 mg hydrocodone/acetaminophen (a combination opioid medication used for pain management) labeled for use by Resident #39 was withdrawn from the medication cart and borrowed for Resident #158 on 2/23/17 at 8:00 PM by Nurse #5. The Controlled Medication Utilization Record is a declining inventory record of individual controlled substance medications</p>	F 281	<p>F-281 Corrective action(s) taken for rsdt#158</p> <p>1. Rsdtd #158's MD was notified of made aware of the improper medication on 3/3/17. No new orders were noted by the MD</p> <p>2. The nurse involved in Rsdtd #158's improper medication administration was reeducated by the ADON on medication administration that included the 5 rights of medication administration and not borrowing medications from one rsdt for another rsdt by the ADON on 3/3/17.</p> <p>*Corrective action(s) taken for residents having potential to be affected by the same practice.</p> <p>1. A 100% audit was completed by the DON and the ADON on 3/3/17 on all rsdts with current MD orders to</p>		

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F 281	<p>Continued From page 9</p> <p>stored on the medication cart for a resident. Hydrocodone/acetaminophen is a controlled substance medication. Nurse #5 ' s signature on the narcotic log was identified by the facility ' s Director of Nursing (DON).</p> <p>A review of Resident #158 ' s Medication Administration Record (MAR) and nursing progress notes revealed there were no notes in her medical record to indicate hydrocodone/acetaminophen was given to the resident. No order was received to give hydrocodone/APAP to Resident #158.</p> <p>An interview was attempted on 3/3/17 at 10:27 AM with Resident #158. The resident was verbal but not able to answer questions appropriately.</p> <p>An interview was conducted on 3/3/17 at 11:18 AM with Nurse #1. Nurse #1 assumed responsibility as the Unit Manager. Upon review of Resident #158 ' s medical record, Nurse #1 stated the resident ' s admission medications would have been written based on the hospital discharge orders. He reported the oxycodone/acetaminophen was ordered for Resident #158 the night of 2/23/17. Nurse #1 confirmed no physician ' s order was received to administer hydrocodone/acetaminophen to Resident #158.</p> <p>An interview was conducted on 3/3/17 at 11:35 AM with the facility ' s DON and Nurse #1 in regards to the discrepancy in the narcotic pain medication ordered versus the medication given to Resident #158. A review of Resident #39 ' s Controlled Medication Utilization Record was completed. Upon inquiry, the DON stated the medication administered to Resident #158 should</p>	F 281	<p>have</p> <p>scheduled and PRN narcotics to</p> <p>determine medication availability for</p> <p>those medications were available for</p> <p>for each individual rsdt identified.</p> <p>2. Med pass observations were completed on all nurses by the DON, ADON, or unit manager. All med pass observations were completed by 3/30/17.</p> <p>*Corrective measures or systemic changes made to ensure that the deficient practice will not occur.</p> <p>1. Mandatory in-servicing was provided to all nurses on the facility's General Dose Preparation and Medication Administration policy that included: the appropriate application of the policy's medication administration guidelines, the 6 rights of medication</p>		

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F 281	<p>Continued From page 10</p> <p>have matched the medication ordered. The DON confirmed the medication reported as given to Resident #158 was not the same medication ordered for her.</p> <p>A telephone interview was conducted on 3/3/17 1:25 PM with Nurse #5. Nurse #5 recalled admitting Resident #158 to the facility on 2/23/17, but did not recall whether or not the resident was experiencing pain that evening. When the nurse was asked about borrowing another resident ' s hydrocodone/acetaminophen and giving it to Resident #158 (instead of the prescribed oxycodone/acetaminophen), Nurse #5 indicated she did not specifically recall this situation. However, the nurse stated, "We have to do that quite often."</p>	F 281	<p>administration, and a DVD and post test on medication administration techniques. In-servicing was provided by the DON and ADON. In-services were completed by 3/30/17.</p> <p>2. Facility emergency narcotic kit was expanded to include increased quantities and more medications by Omnicare Pharmacy on 3/3/17.</p> <p>3. Mandatory in-servicing was provided to all nurses on the facility's Emergency Medication Supply policy that provided guidelines on obtaining narcotics in the event that a rsdt's ordered narcotic were unavailable that outlines the steps to take in the event a ordered medication was unavailable. The DON and ADON provided in-servicing that</p>		

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F 281	Continued From page 11	F 281	<p>were completed by 3/30/17.</p> <p>4. An audit tool was created by the DON to monitor the availability of narcotics for rsdts identified to have orders for controlled medications, and to monitor for compliance with facility policy to not borrow medication from one rsdt to admin to another rsdt.</p> <p>5. Mandatory in-servicing was provided to all nurses on the facility policy Receipt of Interim/Stat/Emergency Deliveries that specifies that medication cannot be borrowed from one rsdt for administration of the medication for another rsdt for all nurses by the DON and ADON.</p> <p>In-servicing was completed by 3/30/17.</p> <p>* Indicate how the facility will monitor performance.</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/03/2017
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F 281	Continued From page 12	F 281	<p>The DON will be responsible for compliance which is achieved by the DON, ADON, or alternate designee by the monitoring of medication administration accuracy as outlined by facility policy that includes the 5 rights of medication administration by auditing/completing med pass observations two times a week for four weeks and then one time a week for eight weeks. Audits will include two nurses on 1st shift, two nurses on 2nd shift, and one nurse on 3rd shift. the DON, ADON, or alternate designee will monitor for narcotic availability for all rsdts with current orders for narcotics and to ensure that the facility policy of the Receipt of Interim/Stat/ Emergency Deliveries guideline that is outlined that medication cannot be</p>		

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F 281	Continued From page 13	F 281	borrowed from rsdt to administer to another rsdt to ensure that practice is/has not occurred by auditing two times a week for four weeks and one time a week for eight weeks. QAPI will review monthly for three months.		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		3/31/17	

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F 329	<p>Continued From page 14</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and pharmacy interviews, the facility: 1) Failed to provide an antianxiety medication in the dose specified by the physician order for 1 of 4 residents (Resident #45) reviewed receiving a controlled substance medication on an as needed basis; and, 2) Failed to provide an antianxiety medication with the correct frequency as specified by the physician order for 1 of 5 residents (Resident #33) reviewed for unnecessary medications.</p> <p>The findings included:</p> <p>1) Resident #45 re-entered the facility on 12/9/15 from the hospital. The resident ' s cumulative diagnoses included anxiety disorder.</p> <p>A review of Resident #45 ' s quarterly Minimum Data Set (MDS) dated 1/23/17 revealed the resident had intact cognitive skills for daily decision making. She required extensive assistance for all of her Activities of Daily Living</p>	F 329	<p>F-329 *Corrective action(s) taken for rsdt #45 and rsdt #33</p> <p>1. Rsdtd # 45's MD was contacted and made aware of the medication rsdt had been receiving on 3/3/17. New orders noted by the MD to d/c the current medication order and order was gave to change the dosage of the medication and to change the administration of the medication from scheduled to PRN.</p> <p>2. Rsdtd # 33's MD was contacted and</p>		

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F 329	<p>Continued From page 15 (ADLs). Section N of the MDS indicated the resident received an antianxiety medication on 2 out of 7 days during the look back period.</p> <p>A review of Resident #45 ' s current Physician Orders revealed her medications included the following, in part: 0.5 milligram (mg) lorazepam given as ½ tablet (0.25 mg) by mouth twice daily as needed for increased anxiety (initiated 2/18/16). Lorazepam is a controlled substance medication used to treat anxiety.</p> <p>A review of Resident #45 ' s Controlled Medication Utilization Record (also known as a narcotic log) included a record for 0.5 mg of lorazepam with 30 tablets dispensed from the pharmacy on 12/11/16. The Controlled Medication Utilization Record is a declining inventory record of individual controlled substance medications stored on the medication cart for a resident. The declining inventory record showed one dose of the 0.5 mg lorazepam tablets remained on the medication cart.</p> <p>An interview was conducted on 3/1/17 at 4:00 PM with Nurse #4. Nurse #4 was the hall nurse assigned to the medication cart containing medications for Resident #45. When asked, the nurse pulled the controlled substance medications for Resident #45 from the medication cart. The pharmacy labeling on the bubble pack controlled substance medication cards were reviewed and compared to the resident's physician orders and Medication Administration Record (MAR). Upon review, Nurse #4 confirmed the dose of lorazepam ordered and listed on Resident #45 ' s MAR (0.5 mg lorazepam to be given as ½ tablet for a 0.25 mg dose) was different from the dose dispensed by</p>	F 329	<p>made aware of the extra medication administration dose on 3/3/17. MD gave order to d/c the duplicate medication order.</p> <p>3. The nurses involved in Rsd#45 and rsdt #33's improper medication administration were in-serviced on the facility's General Dose Preparation and Medication Administration policy that included: the appropriate application of the policy's medication administration guidelines, the 6 rights of medication administration, and a DVD and post test on medication administration techniques. In-servicing was provided by the DON and ADON. In-services were completed by 3/30/17.</p> <p>*Corrective action(s) taken for residents having potential to be</p>		

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F 329	<p>Continued From page 16</p> <p>the pharmacy on 12/11/16 (0.5 mg lorazepam). The pharmacy labeling on the bubble pack medication card for the 0.5 mg lorazepam included instructions to give 1 tablet (not ½ tablet) by mouth twice daily as needed for anxiety. Only 1 of the 30 tablets of 0.5 mg lorazepam dispensed for Resident #45 on 12/11/16 remained in the bubble pack, indicating 29 tablets had been used. The one tablet remaining in the bubble pack was a whole tablet (not ½ of a tablet). During the interview, Nurse #4 reported if only ½ of a lorazepam tablet had been given to the resident at one time, the other one-half tablet would have been noted as "wasted" on the Controlled Medication Utilization Record. This procedure required two nurses' signatures. Upon review, there were no notations of ½ doses either having been given to Resident #45 or "wasted" on the Controlled Medication Utilization Record.</p> <p>An interview was conducted on 3/1/17 at 4:30 PM with the facility ' s Director of Nursing (DON) and Nurse #1. Nurse #1 assumed responsibility as the Unit Manager. Upon review of the discrepancies between the physician orders for Resident #45 ' s lorazepam and dose/instructions for the medication received from the pharmacy, the DON and Unit Manager expressed uncertainty as to why the two were different.</p> <p>A follow-up interview was conducted on 3/2/17 at 9:10 AM with the DON in regards to the discrepancies noted between the physician ' s orders and pharmacy dosing/labeling for Resident #45's lorazepam. The DON reported that she contacted the physician the afternoon of 3/1/17 to inform him of the discrepancies and received new orders for the lorazepam. When asked, the DON indicated she would have expected the</p>	F 329	<p>affected by the same practice.</p> <p>1. A 100% percent audit of rsdts orders was completed by the DON on 3/20/17 for accuracy.</p> <p>2. Med pass observations were completed on all nurses by the DON, ADON, or unit manager. All med pass observations were completed by 3/30/17.</p> <p>*Corrective measures or systemic changes made to ensure that the deficient practice will not occur.</p> <p>1. Mandatory in-servicing was provided to all nurses on the facility's General Dose Preparation and Medication Administration policy that included: the appropriate application of the policy's medication administration guidelines, the 6 rights of medication administration, and a DVD and post</p>		

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F 329	<p>Continued From page 17</p> <p>medications sent out by the pharmacy to be the correct dose and labeled with the correct instructions. She acknowledged the resident had apparently received 0.5 mg doses of lorazepam instead of the 0.25 mg doses ordered by the physician.</p> <p>A telephone interview was conducted on 3/2/17 at 10:14 AM with the contracted pharmacy ' s dispensing pharmacist.</p> <p>The dispensing pharmacist verified 0.5 mg lorazepam tablets (30 count) were dispensed on 12/11/16 for Resident #45 with instructions to give one tablet by mouth twice daily as needed for anxiety. When asked if she could pull up a copy of the original order for review, the pharmacist indicated she was unable to find the original copy at that time. The pharmacist noted the contracted pharmacy just began servicing the facility on 12/1/16, making some records more difficult to retrieve. Upon inquiry, the dispensing pharmacist reported that if a physician order was written for 1/2 tablet, the pharmacy would pre-package 1/2 tablets for lorazepam. When asked if she would expect the pharmacy labeling (including the instructions) to correlate with the physician ' s order and MAR at the facility, the pharmacist stated, "Oh yeah, definitely."</p> <p>2) Resident #33 re-entered the facility on 12/9/16 from the hospital. The resident ' s cumulative diagnoses included anxiety.</p> <p>A review of Resident #33 ' s quarterly Minimum Data Set (MDS) dated 1/9/17 revealed the resident had moderately impaired cognitive skills for daily decision making. She required supervision for eating and locomotion on/off the unit; limited assistance from staff for bed mobility;</p>	F 329	<p>test on medication administration techniques. In-servicing was provided by the DON and ADON. In-services were completed by 3/30/17.</p> <p>2. An audit tool was created by the DON on the monitoring of medication orders for accuracy.</p> <p>The DON will be responsible for compliance which is achieved by the DON, ADON, or alternate designee by the monitoring of medication administration accuracy as outlined by facility policy that includes the 5 rights of medication administration by auditing/completing med pass observations two times a week for four weeks and then one time a week for eight weeks. Audits will include two nurses on 1rst shift, two nurses on</p>		

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F 329	<p>Continued From page 18</p> <p>and extensive assistance for all of her other Activities of Daily Living (ADLs). Section N of the MDS indicated the resident received an antianxiety medication on 7 out of 7 days during the look back period.</p> <p>A review of Resident #33 ' s current Physician Orders conducted on 3/3/17 revealed her active medication list included the following, in part: 5 milligrams (mg) buspirone to be given as 1 tablet by mouth twice daily for anxiety and scheduled for administration at 8:00 AM and 8:00 PM (initiated on 12/14/16); and, 5 mg buspirone to be given as 1 tablet by mouth twice daily for agitation and scheduled for administration at 8:00 AM and 4:00 PM (initiated 3/2/17). Buspirone is an antianxiety medication.</p> <p>An interview was conducted on 3/3/17 at 2:05 PM with Nurse #1. Nurse #1 assumed responsibility as the Unit Manager. Upon inquiry regarding the two orders for Resident #33 ' s buspirone, Nurse #1 recalled putting the new order dated 3/2/17 into the computer on that date. The nurse reported he did not realize the resident was already prescribed this medication twice daily and confirmed the active medication orders included 3 different scheduled times of administration with two doses of the medication scheduled at 8:00 AM each day.</p> <p>An interview was conducted on 3/3/17 at 2:10 PM with Nurse #3. Nurse #3 was the hall nurse assigned to care for the resident on 1st shift. Upon inquiry regarding the two orders for Resident #33 ' s buspirone, the nurse stated, "Oh, the duplicate order?" Nurse #3 reviewed the resident ' s electronic Medication Administration Record (MAR) which documented that only one</p>	F 329	<p>2nd shift, and one nurse on 3rd shift.</p> <p>QAPI will review monthly for three months. for three months.</p>		

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F 329	Continued From page 19 of the 8:00 AM doses of buspirone were given the morning of 3/3/17; the 2nd 8:00 AM dose was recorded as "No" to indicate it was not given. However, further review of the resident ' s MAR revealed buspirone was given 3 times on 3/2/17 (at 8:00 AM, 4:00 PM, and 8:00 PM). When asked if the nurse had told anybody about noticing the duplicate order, she stated she had not. A follow-up interview was conducted on 3/3/17 at 2:15 PM with Nurse #1. Nurse #1 confirmed 3 doses of buspirone had been to Resident #33 on 3/2/17. When asked how long the duplicate order would have continued to be an active order without being questioned, he stated he didn't know. Nurse #1 reported he would contact the physician to let him know the resident was already on buspirone twice daily so he could decide what medication regimen would be most appropriate for the resident at this time. An interview was conducted on 3/3/17 at 2:50 PM with the facility ' s Director of Nursing (DON). During the interview, a review of Resident #33 ' s buspirone orders and MAR was completed. Upon inquiry, the DON stated she would expect staff to immediately notify the charge nurse of a duplicate medication order so it could be taken care of. The DON also reported the nurse noticing the duplicate order could have clarified the order herself.	F 329			
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its-	F 332		3/31/17	

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F 332	<p>Continued From page 20</p> <p>(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to have a medication error rate less than 5% as evidenced by 3 medication errors out of 34 opportunities, resulting in a medication error rate of 8.8%, for 1 of 3 residents (Resident #68) observed during medication pass.</p> <p>The findings included:</p> <p>1) On 3/1/17 at 11:10 AM, Nurse #6 was observed as she prepared and administered medications to Resident #68. The administered medications included 20 milligrams (mg) prednisone given as one tablet by mouth. Prednisone is a corticosteroid medication used for inflammation, suppression of the immune system, and/or treatment of endocrine disorders (related to hormone secretions).</p> <p>According to Lexi-Comp, a comprehensive on-line drug information resource, oral dosage forms of prednisone should be administered after a meal or with food or milk to minimize the risk of gastrointestinal upset.</p> <p>A review of Resident #68 's March 2017 physician 's medication orders included a current order for 20 mg prednisone to be given as 1 tablet by mouth one time a day. The prednisone was scheduled for administration once daily at 8:00 AM.</p> <p>An interview was conducted on 3/1/17 at 11:15 AM with Resident #68. Upon inquiry, the resident</p>	F 332	<p>F-332 *Corrective action(s) taken for rsdt #68</p> <p>1. Rsdt #68's MD was contacted and made aware of the time the medications were administered. MD was made aware of the administration of Senna in place of the ordered Senna D. No new orders were noted by MD.</p> <p>2. The nurse involved in the medication administration of rsdt #68 was provided counseling and re-inservicing on the facility medication administration policy on 3/1/17 by the ADON.</p> <p>* Corrective actions taken for residents having potential to be affected by the same practice.</p> <p>1. A 100% percent audit of rsdts orders</p>		

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F 332	<p>Continued From page 21</p> <p>reported he ate his breakfast around 8:00 AM. He stated he did not eat a morning snack. A review of Resident #68 ' s most recent Minimum Data Set (MDS) assessment (dated 12/22/16) revealed the resident had intact cognitive skills for daily decision making.</p> <p>An interview was conducted on 3/1/17 at 11:50 AM with Nurse #6. When asked about the timing of the prednisone given at 11:10 AM (but scheduled for 8:00 AM administration), the nurse reported she was "running a little bit later than usual" for the hall ' s medication pass.</p> <p>An interview was conducted on 3/1/17 at 1:10 PM with the facility ' s Director of Nursing (DON). During the interview, the DON was asked what her expectations were in regards to Resident #68 ' s prednisone being given 3 hours after his meal and scheduled administration time. The DON reported there was "no reason that should have happened."</p> <p>An interview was conducted on 3/1/17 at 1:23 PM with the facility ' s Medical Doctor (MD). During the interview, the MD stated he was aware of the concerns regarding Resident #68 ' s medications having been administered at 11:00 AM instead of 8:00 AM that morning. He acknowledged the concerns and reported that of the medications administered, he would be most concerned regarding the delay in the prednisone administration.</p> <p>An interview was conducted on 3/2/17 at 10:41 AM with the facility ' s consultant pharmacist. Upon inquiry, the consultant pharmacist reported the administration time of Resident #68 ' s prednisone was, "certainly outside of the window</p>	F 332	<p>was completed by the DON on 3/20/17 for the appropriate scheduling of medications.</p> <p>2. A new medication pass schedule was implemented by the DON and ADON on 3/20/17.</p> <p>3. Med pass observations were completed on all nurses by the DON, ADON, or unit manager. All med pass observations were completed by 3/30/17.</p> <p>*Corrective measures or systemic changes made to ensure that the deficient practice will not occur.</p> <p>1. Mandatory in-servicing was provided to all nurses on the facility's General Dose Preparation and Medication Administration policy that included: the appropriate application of the policy's medication administration</p>		

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F 332	<p>Continued From page 22</p> <p>we would encourage." The pharmacist confirmed prednisone should be given with a meal or with food due to the potential for adverse effects. He stated this medication was not something that should be given at 11:00 AM without food.</p> <p>2) On 3/1/17 at 11:10 AM, Nurse #6 was observed as she prepared and administered medications to Resident #68. The administered medications included two - 10 milliequivalent (mEq) potassium chloride extended release (ER) capsules given by mouth (total dose of 20 mEq). Potassium chloride is a medication used to prevent or treat low levels of potassium in the blood.</p> <p>According to Lexi-Comp, a comprehensive on-line drug information resource, oral dosage forms of potassium chloride should be taken with meals to minimize the risk of gastrointestinal irritation.</p> <p>A review of Resident #68 ' s March 2017 physician ' s medication orders included a current order for 20 mEq potassium chloride ER to be given one time a day for low potassium. The potassium chloride was scheduled for administration once daily at 8:00 AM.</p> <p>An interview was conducted on 3/1/17 at 11:15 AM with Resident #68. Upon inquiry, the resident reported he ate his breakfast around 8:00 AM. He stated he did not eat a morning snack. A review of Resident #68 ' s most recent Minimum Data Set (MDS) assessment (dated 12/22/16) revealed the resident had intact cognitive skills for daily decision making.</p> <p>An interview was conducted on 3/1/17 at 11:50</p>	F 332	<p>guidelines, the 6 rights of medication administration, and a DVD and post test on medication administration techniques. In-servicing was provided by the DON and ADON. In-services were completed by 3/30/17.</p> <p>* Indicate how the facility will monitor performance.</p> <p>The DON will be responsible for compliance which is achieved by the DON, ADON, or alternate designee by the monitoring of medication administration accuracy as outlined by facility policy that includes the 5 rights of medication administration by auditing/completing med pass observations two times a week for four weeks and then one time a week for eight weeks. Audits will include</p>		

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F 332	<p>Continued From page 23</p> <p>AM with Nurse #6. When asked about the timing of the potassium chloride given at 11:10 AM (but scheduled for 8:00 AM administration), the nurse reported she was "running a little bit later than usual" for the hall ' s medication pass.</p> <p>An interview was conducted on 3/1/17 at 1:10 PM with the facility ' s Director of Nursing (DON). During the interview, the DON was asked what her expectations were in regards to Resident #68 ' s potassium chloride being given 3 hours after his meal and scheduled administration time. The DON reported there was "no reason that should have happened."</p> <p>An interview was conducted on 3/2/17 at 10:41 AM with the facility ' s consultant pharmacist. Upon inquiry, the consultant pharmacist reported the administration time of Resident #68 ' s potassium chloride was, "certainly outside of the window we would encourage." The pharmacist confirmed potassium chloride should be given with a meal or with food due to the potential for adverse effects. He stated this medication was not something that should be given at 11:00 AM without food.</p> <p>3) On 3/1/17 at 11:10 AM, Nurse #6 was observed as she prepared and administered medications to Resident #68. The medications pulled for administration included 2 - 8.6 milligram (mg) tablets of sennosides (a stimulant laxative) taken from a stock bottle stored on the medication cart. The nurse was observed as she administered the medication to Resident #68.</p> <p>A review of Resident #68 ' s physician ' s medication orders included a current order for a combination medication containing 8.6 mg</p>	F 332	<p>two nurses on 1rst shift, two nurses on 2nd shift, and one nurse on 3rd shift.</p> <p>QAPI will review monthly for three months. for three months.</p>		

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F 332	Continued From page 24 sennosides and 50 mg docusate sodium (a stool softener) to be given as two tablets by mouth every 12 hours for constipation. An interview was conducted on 3/1/17 at 11:50 AM with Nurse #6. Upon request, the nurse reviewed Resident #68 ' s March 2017 Medication Administration Record (MAR) and the manufacturer ' s labeling on the stock bottle of the tablets given to the resident. The nurse confirmed the medication given was not the combination medication including sennosides and docusate as ordered and indicated by the MAR. An interview was conducted on 3/1/17 at 1:10 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect the nurse to give the correct medication as ordered.	F 332			
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observations, pharmacy and facility staff interviews, and record review, the facility	F 425	F-425 *Corrective actions taken for the	3/31/17	

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F 425	<p>Continued From page 25</p> <p>failed to implement effective procedures for the timely acquisition of medications to meet the needs of each resident and ensure that controlled substance medications belonging to one resident were not "borrowed" for administration to another resident on 3 of 4 Halls (100 Hall, 300 Hall, and 400 Hall).</p> <p>The findings included:</p> <p>A review of the facility's Policy entitled, "New Orders for Schedule II (2) Controlled Substances," dated 12/1/07 (with revisions made on 7/22/08, 5/1/10 and 1/1/13) read, in part: Procedure:</p> <p>1. "New orders for Schedule II controlled substances require a complete written prescription prior to dispensing, unless there is an "Emergency Situation (as defined below). Where permitted under Applicable Law, Facility staff may fax Schedule II prescriptions for long term care residents, terminally ill residents, or where the medication is used for direct infusion (e.g., morphine drop) ...</p> <p>2. Physicians/Prescribers should provide Pharmacy with verbal authorization for Schedule II controlled substances in cases of an "Emergency Situation". An "Emergency Situation" is one in which the prescribing practitioner determines that:</p> <p>2.1 Immediate administration of the Schedule II controlled substance is necessary for proper treatment of the intended ultimate user; and,</p> <p>2.2 There is no appropriate alternative treatment available, including administration of a medication that is not a Schedule II controlled substance; and,</p> <p>2.3 It is not reasonable for</p>	F 425	<p>identified rsdts</p> <p>1. Audits were completed for the rsdts who were identified to have their individual supply of narcotics borrowed from to administer to other rsdts. Rsdts # : 88, 90, 119, 108, 18, 39, 25, 53, 14, 48,122, 109, 45, 50, 156, 106, 160, 46, 16, and 51 to establish current availability of the above identified rsdts individual supply of narcotics for need by the DON, ADON, and Unit Manager on 3/2/17.</p> <p>2. Audits were completed for the rsdts who received narcotics from another rsdt. Rsdts #: 53, 88, 18, 72, 37, 81, 158, 157, 90, 149, 8, 109, 14, 29, 122, 42, 156, 41, 30, 159, 79, and 9 to establish current availability of the above identified rsdts individual supply of narcotics for any need by the DON, ADON, and</p>		

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F 425	<p>Continued From page 26</p> <p>Physician/Prescriber to provide a written prescription to be presented to the person dispensing the Schedule II controlled substance prior to the dispensing.</p> <p>3. For an emergency Schedule II controlled substance order, the Authorized Physician/Prescriber should provide the following information to a licensed pharmacist ...(Items 3.1 - 3.8) ...</p> <p>4. If the controlled substance is needed before the pharmacy can make arrangements for a timely delivery, Facility must fax a request to remove a controlled substance from the emergency drug supply to the pharmacy ...</p> <p>5. Within seven (7) days of requesting an emergency oral prescription, or sooner if required by Applicable Law, the authorized Physician/Prescriber should deliver to Pharmacy a signed written prescription for the prescribed quantity. Physician/Prescriber should fax (where permitted under Applicable Law), mail, or hand deliver the prescription to Pharmacy ..."</p> <p>A review of the facility's Policy entitled, "New Orders for Schedule III-V (3-5) Controlled Substances," dated 12/1/07 (with revisions made on 5/1/10, 6/1/11 and 1/1/13) read, in part: Procedure: 1. "For all Schedule III-V controlled substance medication orders, the facility must provide to the pharmacy: 1.1 A written prescription signed by a practitioner, or, 1.2 A fax of a written, signed prescription transmitted by the practitioner or the practitioner ' s agent to the pharmacy, or, 1.3 An oral prescription communicated by the practitioner or the practitioner ' s agent to the pharmacist.</p>	F 425	<p>Unit Manager on 3/2/17.</p> <p>3. All nurses were immediately in-serviced facility policy of not borrowing medication from one rsdt to administer to another rsdt by the DON and ADON on 3/2/17.</p> <p>4. Rsdts # : 88, 90, 119, 108, 18, 39, 25, 53, 14, 48, 122, 109, 45, 50, 156, 106, 46, 16, 51 were reimbursed by the facility for each individual dose of medication that had been borrowed from each of the above identified rsdts by using the list of rsdt names provided by the surveyor during the recent survey to resupply the correct individual rsdts and amounts by Omnicare pharmacy. The facility was billed for each of the medications replaced for each individual rsdt that had been identified to have narcotics borrowed from them. The</p>		

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F 425	<p>Continued From page 27</p> <p>2. Schedule III-V controlled substance orders should be communicated to Pharmacy as follows:</p> <p>2.1 Facility should ensure that written medication orders are legible when faxed to the Pharmacy.</p> <p>2.2 If the medication is needed before the next scheduled delivery, Facility staff should indicate the exact time by which the medication is needed.</p> <p>2.3 If the controlled substance is needed before the Pharmacy can make arrangements for a timely delivery, Facility must fax a request to remove a controlled substance from Facility ' s Emergency Medication Supply to the pharmacy ..."</p> <p>1) A review of the 100 Hall Controlled Medication Utilization Records (also known as narcotic logs) was conducted on 2/28/17. Controlled Medication Utilization Records are declining inventory records of individual controlled substance medications stored on the medication cart for a resident. This review identified 22 instances during a two week period (from 2/15/17 to 2/28/17) when a controlled substance medication belonging to one resident on the 100 Hall was borrowed for administration to another resident. The borrowed medications included: --On 2/15/17 at 9:00 AM, one tablet of 0.25 milligrams (mg) alprazolam (an antianxiety medication) was borrowed from Resident #88 for administration to Resident #53 by Nurse #7; --On 2/15/17 at 9:00 PM, one tablet of 0.25 mg alprazolam was borrowed from Resident #88 for administration to Resident #53 by Nurse #18; --On 2/18/17 at 8:00 AM, one tablet of 0.25 mg alprazolam was borrowed from Resident #90 for administration to Resident #53 by Nurse #8; --On 2/19/17 at 8:00 PM, one tablet of 7.5/325 mg</p>	F 425	<p>replacements were provided on 3/7/17.</p> <p>* Corrective actions taken for residents having potential to be affected by the same practice.</p> <p>1. 100 % audit of all current rsdts with MD orders for scheduled or PRN individual supplies of narcotics were established to determine any need by the DON, ADON, and Unit Manager on 3/2/17.</p> <p>2. Med pass observations were completed on all nurses by the DON, ADON, or unit manager. All med pass observations were completed by 3/30/17.</p> <p>*Corrective measures or systemic changes made to ensure that the deficient practice will not occur.</p> <p>1. Mandatory in-servicing was provided to all nurses on the facility's</p>		

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F 425	Continued From page 28 hydrocodone/acetaminophen (a combination opioid pain medication) was borrowed from Resident #119 for administration to Resident #88 by an unidentified nurse; --On 2/20/17 at 8:00 PM, one tablet of 0.5 mg lorazepam (an antianxiety medication) was borrowed from Resident #108 for administration to Resident #18 by Nurse #13; --On 2/20/17 at 9:00 PM, one tablet of 7.5/325 mg hydrocodone/acetaminophen was borrowed from Resident #119 for administration to Resident #88 by Nurse #13; --On 2/21/17 at 8:00 AM, one tablet of 0.25 mg lorazepam was borrowed from Resident #18 for administration to Resident #72 by Nurse #7; --On 2/21/17 at 2:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #108 for administration to Resident #37 by Nurse #7; --On 2/21/17 at 5:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #108 for administration to Resident #81 by Nurse #7; --On 2/22/17 at 12:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #108 for administration to Resident #81 by Nurse #2; --On 2/22/17 at 2:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #108 for administration to Resident #81 by Nurse #4; --On 2/22/17 at 4:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #108 for administration to Resident #37 by Nurse #4; --On 2/22/17 at 4:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #108 for administration to Resident #81 by Nurse #4; --On 2/23/17 at 8:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #108 for administration to Resident #81 by Nurse #5; --On 2/23/17 at 8:00 PM, one tablet of 5/325 mg hydrocodone/acetaminophen was borrowed from Resident #39 for administration to Resident #158	F 425	General Dose Preparation and Medication Administration policy that included: the appropriate application of the policy's medication administration guidelines, the 6 rights of medication administration, and a DVD and post test on medication administration techniques. In-servicing was provided by the DON and ADON. In-services were completed by 3/30/17. 2. Facility emergency narcotic kit was expanded to include increased quantities and more medications by Omnicare Pharmacy on 3/3/17. 3. Mandatory in-servicing was provided to all nurses on the facility's Emergency Medication Supply policy that provided guidelines on obtaining narcotics in the event that a rsdt's ordered narcotic		

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F 425	<p>Continued From page 29</p> <p>by Nurse #5; --On 2/23/17 at 9:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #108 for administration to Resident #37 by Nurse #5; --On 2/24/17 at 1:00 PM, one tablet of 1 mg lorazepam was borrowed from Resident #108 for administration to Resident #72 by Nurse #8; --On 2/24/17 at 8:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #108 for administration to Resident #37 by an unidentified nurse; --On 2/25/17 at 11:45 PM, one tablet of 5/325 mg hydrocodone/acetaminophen was borrowed from Resident #25 for administration to Resident #157 by Nurse #13; --On 2/26/17 at 3:00 AM, one tablet of 5 mg oxycodone (an opioid pain medication) was borrowed from Resident #53 for administration to Resident #90 by Nurse #13. --On 2/26/17 at 8:00 AM, one tablet of 0.25 mg lorazepam was borrowed from Resident #18 for administration to Resident #37 by Nurse #7; --On 2/27/17 at 8:00 AM, one tablet of 0.25 mg alprazolam was borrowed from Resident #88 for administration to Resident #81 by Nurse #8.</p> <p>An interview was conducted on 2/28/17 at 3:00 PM with the facility 's Director of Nursing (DON). During the interview, the DON reported the facility transitioned from one pharmacy to another on 12/1/16. She reported there were multiple challenges during the pharmacy transition, primarily from software issues and the ordering procedures for medications. The DON stated she felt the pharmaceutical system and receipt of medications had improved over the past two weeks or so. A follow-up interview was conducted on 2/28/17 at 4:30 PM with the DON. At that time, the DON reported she had not been</p>	F 425	<p>were unavailable that outlines the steps to take in the event a ordered medication was unavailable. The DON and ADON provided in-servicing that were completed by 3/30/17.</p> <p>4. An audit tool was created by the DON to monitor the availability of narcotics for rsdts identified to have orders for controlled medications, and to monitor for compliance with facility policy to not borrow medication from one rsdt to admin to another rsdt.</p> <p>5. Mandatory in-servicing was provided to all nurses on the facility policy Receipt of Interim/Stat/Emergency Deliveries that specifies that medication cannot be borrowed from one rsdt for administration of the medication for another rsdt for all nurses by the DON and ADON.</p> <p>In-servicing was completed by</p>		

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F 425	<p>Continued From page 30</p> <p>made aware there was a concern with the availability of controlled substance medications for residents and did not realize controlled substance medications were being borrowed from one resident to another.</p> <p>An interview was conducted on 3/1/17 at 8:30 AM with the DON. During the interview, the DON consented to provide assistance in identifying nurses' signatures on the Controlled Medication Utilization Records.</p> <p>An interview was conducted on 3/1/17 at 1:55 PM with Nurse #8. Nurse #8 was identified as having borrowed a controlled substance medication from one resident to another 3 times from 2/15/17 - 2/28/17 on the 100 Hall. During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents' needs and the practice of borrowing medications from one resident to another. Nurse #8 stated that if the resident was out of a medication, she would borrow the controlled substance from another resident. The nurse reported she had just been in-serviced on the facility's procedures for the ordering of medications.</p> <p>An interview was conducted on 3/1/17 at 2:00 PM with Nurse #7. Nurse #7 was identified as having borrowed a controlled substance medication from one resident to another on 5 occasions from 2/15/17 - 2/28/17 on the 100 Hall. During the interview, the nurse stated she only borrowed a controlled substance from one resident for another if someone was out of their medication. The nurse stated she was not aware the facility prohibited the borrowing of controlled substance medications. The nurse stated the availability of</p>	F 425	<p>3/30/17.</p> <p>* Indicate how the facility will monitor performance.</p> <p>The DON will be responsible for compliance which is achieved by the DON, ADON, or alternate designee by the monitoring of medication administration accuracy as outlined by facility policy that includes the 5 rights of medication administration by auditing/completing med pass observations two times a week for four weeks and then one time a week for eight weeks. Audits will include two nurses on 1st shift, two nurses on 2nd shift, and one nurse on 3rd shift.</p> <p>the DON, ADON, or alternate designee will monitor for narcotic availability</p>		

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F 425	<p>Continued From page 31</p> <p>medications had been an issue for as long as a year and noted it had not become noticeably worse in the last 3 months. Nurse #7 was aware of the facility ' s procedure to order a controlled substance medication. When asked about the facility ' s backup pharmacy, the nurse stated she had not utilized it.</p> <p>An interview was conducted on 3/1/17 at 4:00 PM with Nurse #4. Nurse #4 was identified as having borrowed a controlled substance medication from one resident to another on 3 occasions from 2/15/17 - 2/28/17 on the 100 Hall. During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents ' needs and the practice of borrowing medications from one resident to another. Upon review of the narcotic logs, the nurse identified her initials on the forms. The nurse stated she would occasionally borrow a controlled substance medication from one resident to another if she received a new order or had a new admission without the medication coming from the pharmacy for that resident. The nurse stated she was in-serviced on this practice and was no longer supposed to borrow controlled substance medications. Instead, the nurse reported she was instructed to call the pharmacy and get the medication sent out from them or their backup pharmacy.</p> <p>An interview was conducted on 3/1/17 at 4:35 PM with Nurse #1. Nurse #1 assumed responsibility as the Unit Manager. During the interview, Nurse #1 reported the new pharmacy typically made a "run" between 3:00-4:00 PM every day, and a "sweep run" (when the bulk of the medications would be delivered) between 3:00 and 6:00 AM daily. He also noted the pharmacy had arranged</p>	F 425	<p>for all rsdts with current orders for narcotics and to ensure that the facility policy of the Receipt of Interim/Stat/ Emergency Deliveries guideline that is outlined that medication cannot be borrowed from rsdt to administer to another rsdt to ensure that practice is/has not occurred by auditing two times a week for four weeks and one time a week for eight weeks.</p> <p>QAPI will review monthly for three months.</p>		

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

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F 425	<p>Continued From page 32</p> <p>a back-up pharmacy for use on an as needed basis. However, he reported the receipt of medications from the back up pharmacy typically took "at least 2 hours." Nurse #1 stated he was responsible for putting most of the pharmacy orders into the computer and faxing the scripts for controlled substances to the pharmacy. Although this process was typically completed by 5:00 PM or so, he noted the hall nurse was required to verify these orders and the pharmacy wouldn't see the medication orders until the nurse had approved them. Nurse #1 reported this verification of orders may be delayed and not be completed until 10:00 PM or later, depending on the hall nurse ' s resident care duties.</p> <p>An interview was conducted on 3/2/17 at 6:55 AM with Nurse #13. Nurse #13 was identified as having borrowed a controlled substance medication from one resident to another on 4 occasions from 2/15/17 - 2/28/17 on the 100 Hall. During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents ' needs and the practice of borrowing medications. Upon review of the narcotic logs from the past 2 weeks, Nurse #13 identified her signature and acknowledged she borrowed medications (including controlled substances) from one resident to another if a resident was out of his/her medication and needed to receive it. She reported the facility had a new pharmacy the last few months and there have been "more issues" with medication availability than with the previous pharmacy. The nurse reported she has now been in-serviced regarding the facility policy which does not allow for the borrowing of controlled substances. The nurse stated she has been instructed to notify the pharmacy of any</p>	F 425			

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F 425	<p>Continued From page 33</p> <p>need for resident's medication. She reported the pharmacy was responsible to contact the back-up pharmacy, if needed, to deliver the medication.</p> <p>An interview was conducted on 3/2/17 at 1:30 PM with Nurse #2. Nurse #2 was identified as having borrowed a controlled substance from one resident to another on one occasion from 2/15/17 - 2/28/17 on the 100 Hall. When the availability of controlled substance medications and borrowing of them were discussed with the nurse, Nurse #2 reported, "The only reason why I would borrow it is because she (the resident) didn't have it (the medication)." The nurse stated the situation just randomly happened. However, she reported the process had changed at the facility and a nurse can no longer borrow a medication from one resident to another. Nurse #2 reported she has been in-serviced to notify the physician if a resident is out of a medication and to try to call the pharmacy so the backup pharmacy could deliver the medication, if needed.</p> <p>A telephone interview was conducted on 3/2/17 at 9:47 AM with the contract pharmacy 's Customer Service and Account Manager. The Manager reported she was working with the facility 's DON to identify several things that could help improve the timely availability of medications, including having the nurses become proactive when doing shift change and identifying medications that are getting low (before running out). Upon inquiry, the Manager reported the cut-off time for ordering medication refills was 3:00 PM and for new orders it was 5:00 PM Monday through Friday. The Manager reported medications were delivered nightly (leaving the pharmacy around 7:00 PM), with smaller runs and "mini-stat" runs that leave the pharmacy around 10:30 AM, 2:30</p>	F 425			

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F 425	<p>Continued From page 34</p> <p>PM, and 1:00 AM. Upon inquiry, she stated the pharmacy did deliver on Saturday at the regular delivery time; and, on Sundays they utilized their after-hours protocol with the use of a backup pharmacy as needed. When the Manager was asked about the availability of controlled substance medications, she reported a hard script was needed for all controlled substances. However, she stated the prescription could be called in by the prescriber if the facility needed a Schedule III - V controlled substance medication. If a resident needed a Schedule II controlled substance medication and the physician called it in, the pharmacy had the ability to enact the emergency Drug Enforcement Agency (DEA) rule. The Account Manager stated, "We don't authorize any borrowing of controlled substances or any medications."</p> <p>A telephone interview was conducted on 3/2/17 at 10:41 AM with the facility ' s consultant pharmacist. The pharmacist reported she had talked with the DON this week in regards to the borrowing of medications, and stated, "The issue is the medication is not there." He reported the pharmacy was working with the facility to figure out what the problems were in regards to the medications not being available when they were needed for a resident. When asked if he had previously identified a concern regarding the borrowing of medications (including controlled substances), he reported he had not. Upon inquiry, he reported the role of the consultant pharmacist during the transition to the new pharmacy included providing education and orienting staff to the pharmacy ' s policies and procedures. The pharmacist stated he was a point of contact to deal with issues such as medication dispensing and ordering, and to help</p>	F 425			

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F 425	<p>Continued From page 35 coordinate whatever needed to be done.</p> <p>An attempt was made to interview Nurse #18 by telephone on 3/3/17 at 8:57 AM. There was no answer so a message was left requesting a return call. Nurse #18 was identified as having borrowed a controlled substance medication from one resident to another on 1 occasion from 2/15/17 - 2/28/17 on the 100 Hall. Nurse #18 did not return the phone call.</p> <p>An interview was conducted on 3/3/17 at 11:45 AM with the facility ' s DON. During the interview, the DON discussed how the facility prepared for the pharmacy transition made on 12/1/16 to ensure resident medications continued to be received on a timely basis as needed. The DON reported the facility received emails informing them of the pharmacy transition, they had a pharmacy representative meet with 8-9 nurses prior to the transition date on general pharmacy issues, and the facility was provided written materials (including the pharmacy policies and procedures) on the day of the change to the new pharmacy. When asked what role the consultant pharmacist had during this transition, the DON reported he did not have a visible role in the facility during the transition period to the new pharmacy. Upon inquiry, the DON stated that her expectation was for every resident to have their medication in the facility, as ordered by the physician.</p> <p>A telephone interview was conducted on 3/3/17 at 1:25 PM with Nurse #5. Nurse #5 was no longer employed by the facility. The nurse was identified as having borrowed a controlled substance medication from one resident to another on 3 occasions from 2/15/17 - 2/28/17 on the 100 Hall.</p>	F 425			

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F 425	<p>Continued From page 36</p> <p>During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents ' needs and the practice of borrowing medications from one resident to another. In regards to the borrowing of controlled substance medications, the nurse stated, "We have to do that quite often." Nurse #5 reported that when a medication was not available for a resident, she would sometimes go to another hall to find the correct dose of a medication so she could borrow it for the resident who was out.</p> <p>2) A review of the 300 Hall Controlled Medication Utilization Records (also known as narcotic logs) was conducted on 2/28/17. Controlled Medication Utilization Records are declining inventory records of individual controlled substance medications stored on the medication cart for a resident. This review identified 29 instances during a two week period (from 2/15/17 to 2/28/17) when a controlled substance medication belonging to one resident on the 300 Hall was borrowed for administration to another resident. The borrowed medications included: --On 2/15/17 at 1:30 AM, one tablet of 5/325 milligrams (mg) hydrocodone/acetaminophen (a combination opioid pain medication) was borrowed from Resident #14 for administration to Resident #149 by Nurse #18; --On 2/16/17 at 9:20 AM, one tablet of 5/325 mg hydrocodone/acetaminophen was borrowed from Resident #14 for administration to Resident #149 by Nurse #10; --On 2/16/17 at 6:00 PM, one tablet of 5/325 mg hydrocodone/acetaminophen was borrowed from Resident #14 for administration to Resident #149 by Nurse #10; --On 2/17/17 at 8:00 AM, one tablet of 5/325 mg</p>	F 425			

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F 425	Continued From page 37 hydrocodone/acetaminophen was borrowed from Resident #14 for administration to Resident #149 by Nurse #15; --On 2/17/17 at 10:00 PM, one tablet of 0.125 mg alprazolam (an antianxiety medication) was borrowed from Resident #48 for administration to Resident #8 by Nurse #5; --On 2/18/17 at 8:00 AM, one tablet of 5/325 mg hydrocodone/acetaminophen was borrowed from Resident #14 for administration to Resident #149 by Nurse #3; --On 2/18/17 at 9:00 AM, one tablet of 0.5 mg lorazepam (an antianxiety medication) was borrowed from Resident #122 for administration to Resident #109 by Nurse #3; --On 2/18/17 at 10:30 PM, one tablet of 0.125 mg alprazolam was borrowed from Resident #48 for administration to Resident #8 by Nurse #5; --On 2/19/17 at 9:00 AM, one tablet of 0.5 mg lorazepam was borrowed from Resident #122 for administration to Resident #109 by Nurse #3; --On 2/19/17 at 9:00 AM, one tablet of 5/325 mg hydrocodone/acetaminophen was borrowed from Resident #14 for administration to Resident #149 by Nurse #3; --On 2/19/17 at 9:00 PM, one tablet of 5/325 mg hydrocodone/acetaminophen was borrowed from Resident #14 for administration to Resident #149 by Nurse #5; --On 2/19/17 at 10:30 PM, one tablet of 0.125 mg alprazolam was borrowed from Resident #48 for administration to Resident #8 by Nurse #5; --On 2/20/17 at 8:00 AM, one tablet of 5/325 mg hydrocodone/acetaminophen was borrowed from Resident #14 for administration to Resident #149 by Nurse #15; --On 2/20/17 at 5:20 PM, one tablet of 5/325 mg hydrocodone/acetaminophen was borrowed from Resident #14 for administration to Resident #149	F 425			

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F 425	Continued From page 38 by Nurse 11; --On 2/20/17 at 8:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #122 for administration to Resident #109 by Nurse #18; --On 2/20/17 at 8:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #122 for administration to Resident #29 by Nurse #18; --On 2/20/17 at 10:00 PM, one tablet of 5/325 mg hydrocodone/acetaminophen was borrowed from Resident #14 for administration to Resident #149 by Nurse #11; --On 2/21/17 at 8:00 AM, two tablets of 5/325 mg hydrocodone/acetaminophen were borrowed from Resident #14 for administration to Resident #149 by Nurse #3; --On 2/21/17 at 9:00 AM, one tablet of 0.5 mg lorazepam was borrowed from Resident #122 for administration to Resident #109 by Nurse #3; --On 2/21/17 at 9:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #45 for administration to Resident #109 by Nurse #18; --On 2/22/17 at 9:00 AM, one tablet of 0.5 mg lorazepam was borrowed from Resident #122 for administration to Resident #109 by Nurse #3; --On 2/22/17 at 2:30 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #45 for administration to Resident #122 by Nurse #18; --On 2/22/17 at 9:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #122 for administration to Resident #109 by an unidentified nurse; --On 2/23/17 at 6:00 PM, two tablets of 5 mg oxycodone (an opioid pain medication) was borrowed from Resident #50 for administration to Resident #42 by Nurse #4; --On 2/24/17 at 3:00 AM, one tablet of 0.5 mg lorazepam was borrowed from Resident #122 for administration to Resident #109 by Nurse #18; --On 2/24/17 at 7:00 PM, one tablet of 0.5 mg	F 425			

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F 425	<p>Continued From page 39</p> <p>lorazepam was borrowed from Resident #122 for administration to Resident #109 by Nurse #5; --On 2/25/17 at 8:00 AM, one tablet of 0.5 mg lorazepam was borrowed from Resident #122 for administration to Resident #29 by an unidentified nurse; --On 2/26/17 at 2:00 AM, two tablets of 5 mg oxycodone were borrowed from Resident #98 for administration to Resident #156 by an unidentified nurse; --On 2/27/17 at 9:00 PM, one tablet of 5 mg oxycodone was borrowed from Resident #98 for administration to Resident #156 by Nurse #4.</p> <p>An interview was conducted on 2/28/17 at 3:00 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported the facility transitioned from one pharmacy to another on 12/1/16. She reported there were multiple challenges during the pharmacy transition, primarily from software issues and the ordering procedures for medications. The DON stated she felt the pharmaceutical system and receipt of medications had improved over the past two weeks or so. A follow-up interview was conducted on 2/28/17 at 4:30 PM with the DON. At that time, the DON reported she had not been made aware there was a concern with the availability of controlled substance medications for residents and did not realize controlled substance medications were being borrowed from one resident to another.</p> <p>An interview was conducted on 3/1/17 at 8:30 AM with the DON. During the interview, the DON consented to provide assistance in identifying nurses' signatures on the Controlled Medication Utilization Records.</p>	F 425			

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F 425	<p>Continued From page 40</p> <p>An interview was conducted on 3/1/17 at 3:47 PM with Nurse #11. Nurse #11 was identified as having borrowed a controlled substance medication from one resident to another on 2 occasions from 2/15/17 - 2/28/17 on the 300 Hall. During the interview, the nurse reported she borrowed a controlled substance medication from one resident to another if a resident did not have the medication he/she needed. The nurse stated the facility has had problems getting medications when needed by the residents.</p> <p>An interview was conducted on 3/1/17 at 4:00 PM with Nurse #4. Nurse #4 was identified as having borrowed a controlled substance medication from one resident to another on 2 occasions from 2/15/17 - 2/28/17 on the 300 Hall. During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents' needs and the practice of borrowing medications from one resident to another. Upon review of the narcotic logs, the nurse identified her initials on the forms. The nurse stated she would occasionally borrow a controlled substance medication from one resident to another if she received a new order or had a new admission without the medication coming from the pharmacy for that resident. The nurse stated she was in-serviced on this practice and was no longer supposed to borrow controlled substance medications. Instead, the nurse reported she was instructed to call the pharmacy and get the medication sent out from them or their backup pharmacy.</p> <p>An interview was conducted on 3/1/17 at 4:15 PM with Nurse #10. Nurse #10 was identified as having borrowed a controlled substance medication from one resident to another on 2</p>	F 425			

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F 425	<p>Continued From page 41</p> <p>occasions from 2/15/17 - 2/28/17 on the 300 Hall. During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents ' needs and the practice of borrowing medications from one resident to another. Upon review, the nurse confirmed her signature on the narcotic log. Nurse #10 stated she has since been made aware the practice of borrowing medications was no longer allowed. At this point, the nurse reported that if a resident was out of a controlled substance medication, she was supposed to look in the facility ' s new narcotic kit and sign out the medication, if available. Alternatively, Nurse #10 stated she could call the pharmacy to let them know when she needed a medication delivered.</p> <p>An interview was conducted on 3/1/17 at 4:35 PM with Nurse #1. Nurse #1 assumed responsibility as the Unit Manager. During the interview, Nurse #1 reported the new pharmacy typically made a "run" between 3:00-4:00 PM every day, and a "sweep run" (when the bulk of the medications would be delivered) between 3:00 and 6:00 AM daily. He also noted the pharmacy had arranged a back-up pharmacy for use on an as needed basis. However, he reported the receipt of medications from the back up pharmacy typically took "at least 2 hours." Nurse #1 stated he was responsible for putting most of the pharmacy orders into the computer and faxing the scripts for controlled substances to the pharmacy. Although this process was typically completed by 5:00 PM or so, he noted the hall nurse was required to verify these orders and the pharmacy wouldn't see the medication orders until the nurse had approved them. Nurse #1 reported this verification of orders may be delayed and not be completed until 10:00 PM or later, depending on</p>	F 425			

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F 425	<p>Continued From page 42</p> <p>the hall nurse ' s resident care duties.</p> <p>A telephone interview was conducted on 3/2/17 at 9:47 AM with the contract pharmacy ' s Customer Service and Account Manager. The Manager reported she was working with the facility ' s DON to identify several things that could help improve the timely availability of medications, including having the nurses become proactive when doing shift change and identifying medications that are getting low (before running out). Upon inquiry, the Manager reported the cut-off time for ordering medication refills was 3:00 PM and for new orders it was 5:00 PM Monday through Friday. The Manager reported medications were delivered nightly (leaving the pharmacy around 7:00 PM), with smaller runs and "mini-stat" runs that leave the pharmacy around 10:30 AM, 2:30 PM, and 1:00 AM. Upon inquiry, she stated the pharmacy did deliver on Saturday at the regular delivery time; and, on Sundays they utilized their after-hours protocol with the use of a backup pharmacy as needed. When the Manager was asked about the availability of controlled substance medications, she reported a hard script was needed for all controlled substances. However, she stated the prescription could be called in by the prescriber if the facility needed a Schedule III - V controlled substance medication. If a resident needed a Schedule II controlled substance medication and the physician called it in, the pharmacy had the ability to enact the emergency Drug Enforcement Agency (DEA) rule. The Account Manager stated, "We don't authorize any borrowing of controlled substances or any medications."</p> <p>A telephone interview was conducted on 3/2/17 at 10:41 AM with the facility ' s consultant</p>	F 425			

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F 425	<p>Continued From page 43</p> <p>pharmacist. The pharmacist reported she had talked with the DON this week in regards to the borrowing of medications, and stated, "The issue is the medication is not there." He reported the pharmacy was working with the facility to figure out what the problems were in regards to the medications not being available when they were needed for a resident. When asked if he had previously identified a concern regarding the borrowing of medications (including controlled substances), he reported he had not. Upon inquiry, he reported the role of the consultant pharmacist during the transition to the new pharmacy included providing education and orienting staff to the pharmacy 's policies and procedures. The pharmacist stated he was a point of contact to deal with issues such as medication dispensing and ordering, and to help coordinate whatever needed to be done.</p> <p>An interview was conducted on 3/2/17 at 1:45 PM with Nurse #3. Nurse #3 was identified as having borrowed a controlled substance medication from one resident to another on 7 occasions from 2/15/17 - 2/28/17 on the 300 Hall. The nurse confirmed her signature on the Narc log. Upon inquiry as to what circumstances prompted the nurse to borrow controlled substance medications from one resident to another, the nurse stated, "They (the residents) were out." Upon inquiry, the nurse stated she has since been in-serviced and informed the facility does not allow borrowing of medications from one resident to another. Nurse #3 reported she was instructed to call the pharmacy and request the medication, which may be sent via their back up pharmacy.</p> <p>An interview was conducted on 3/2/17 at 2:00 PM with Nurse #15. Nurse #15 was identified as</p>	F 425			

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F 425	<p>Continued From page 44</p> <p>having borrowed a controlled substance medication from one resident to another on 2 occasions from 2/15/17 - 2/28/17 on the 300 Hall. During the interview, the nurse confirmed her signature on the narcotic logs. Nurse #15 stated it has been challenging to get all medications (not just controlled substances) from the pharmacy on a timely basis. The nurse indicated she was made aware that borrowing was no longer allowed. She understood there would be a selection of controlled substance medications available in the medication room that could be signed out and used until the resident ' s medication was received from the pharmacy.</p> <p>An attempt was made to interview Nurse #18 by telephone on 3/3/17 at 8:57 AM. There was no answer so a message was left requesting a return call. Nurse #18 was identified as having borrowed a controlled substance medication from one resident to another on 6 occasions from 2/15/17 - 2/28/17 on the 300 Hall. Nurse #18 did not return the phone call.</p> <p>An interview was conducted on 3/3/17 at 11:45 AM with the facility ' s DON. During the interview, the DON discussed how the facility prepared for the pharmacy transition made on 12/1/16 to ensure resident medications continued to be received on a timely basis as needed. The DON reported the facility received emails informing them of the pharmacy transition, they had a pharmacy representative meet with 8-9 nurses prior to the transition date on general pharmacy issues, and the facility was provided written materials (including the pharmacy policies and procedures) on the day of the change to the new pharmacy. When asked what role the consultant pharmacist had during this transition, the DON</p>	F 425			

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F 425	<p>Continued From page 45</p> <p>reported he did not have a visible role in the facility during the transition period to the new pharmacy. Upon inquiry, the DON stated that her expectation was for every resident to have their medication in the facility, as ordered by the physician.</p> <p>A telephone interview was conducted on 3/3/17 at 1:25 PM with Nurse #5. Nurse #5 was no longer employed by the facility. The nurse was identified as having borrowed a controlled substance medication from one resident to another on 5 occasions from 2/15/17 - 2/28/17 on the 300 Hall. During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents ' needs and the practice of borrowing medications from one resident to another. In regards to the borrowing of controlled substance medications, the nurse stated, "We have to do that quite often." Nurse #5 reported that when a medication was not available for a resident, she would sometimes go to another hall to find the correct dose of a medication so she could borrow it for the resident who was out.</p> <p>3) A review of the 400 Hall Controlled Medication Utilization Records (also known as narcotic logs) was conducted on 2/28/17. Controlled Medication Utilization Records are declining inventory records of individual controlled substance medications stored on the medication cart for a resident. This review identified 22 instances during a two week period (from 2/15/17 to 2/28/17) when a controlled substance medication belonging to one resident on the 400 Hall was borrowed for administration to another resident. The borrowed medications included: --On 2/16/17 at 9:00 PM, one tablet of 1 milligram</p>	F 425			

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F 425	Continued From page 46 (mg) clonazepam (an antianxiety medication) was borrowed from Resident #106 for administration to Resident #41 by Nurse #5; --On 2/19/17 at 9:00 PM, one tablet of 0.5 mg lorazepam (an antianxiety medication) was borrowed from Resident #160 for administration to Resident #72 by Nurse #18; --On 2/19/17 at 9:00 PM, two tablets of 100 mg Vimpat (an anticonvulsant medication) were borrowed from Resident #46 for administration to Resident #149 by Nurse #5; --On 2/20/17 at 8:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #160 for administration to Resident #30 by Nurse #13; --On 2/21/17 at 1:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #160 for administration to Resident #72 by Nurse #7; --On 2/21/17 at 8:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #160 for administration to Resident #72 by Nurse #13; --On 2/22/17 at 8:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #159 by Nurse #12; --On 2/23/17 at 5:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #79 by Nurse #10; --On 2/24/17 at 5:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #79 by Nurse #10; --On 2/25/17 at 1:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #9 by Nurse #3; --On 2/25/17 at 4:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #79 by Nurse #3; --On 2/25/17 at 8:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #9 by Nurse #3; --On 2/25/17 at 8:00 PM, one tablet of 5/325 mg	F 425			

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F 425	<p>Continued From page 47</p> <p>hydrocodone/acetaminophen (a combination opioid pain medication) was borrowed from Resident #51 for administration to Resident #9 by Nurse #3;</p> <p>--On 2/26/17 at 1:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #9 by Nurse #3;</p> <p>--On 2/26/17 at 4:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #79 by Nurse #3;</p> <p>--On 2/26/17 at 8:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #9 by Nurse #3;</p> <p>--On 2/27/17 at 9:00 AM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #9 by Nurse #9;</p> <p>--On 2/27/17 at 1:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #9 by Nurse #9;</p> <p>--On 2/27/17 at 5:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #79 by Nurse #10;</p> <p>--On 2/27/17 at 9:30 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #160 for administration to Resident #9 by Nurse #10;</p> <p>--On 2/28/17 at 9:00 AM, one tablet of 0.5 mg lorazepam was borrowed from Resident #16 for administration to Resident #9 by Nurse #9;</p> <p>--On 2/28/17 at 1:00 PM, one tablet of 0.5 mg lorazepam was borrowed from Resident #160 for administration to Resident #9 by Nurse #9.</p> <p>An interview was conducted on 2/28/17 at 3:00 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported the facility transitioned from one pharmacy to another on 12/1/16. She reported there were multiple challenges during the pharmacy transition, primarily from software issues and the ordering</p>	F 425			

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F 425	<p>Continued From page 48</p> <p>procedures for medications. The DON stated she felt the pharmaceutical system and receipt of medications had improved over the past two weeks or so. A follow-up interview was conducted on 2/28/17 at 4:30 PM with the DON. At that time, the DON reported she had not been made aware there was a concern with the availability of controlled substance medications for residents and did not realize controlled substance medications were being borrowed from one resident to another.</p> <p>An interview was conducted on 3/1/17 at 8:30 AM with the DON. During the interview, the DON consented to provide assistance in identifying nurses' signatures on the Controlled Medication Utilization Records.</p> <p>An interview was conducted on 3/1/17 at 2:00 PM with Nurse #7. Nurse #7 was identified as having borrowed a controlled substance medication from one resident to another on 1 occasion from 2/15/17 - 2/28/17 on the 400 Hall. During the interview, the nurse stated she had only borrowed a controlled substance from one resident for another if someone was out of their medication. The nurse stated she was not aware the facility prohibited the borrowing of controlled substance medications. The nurse stated the availability of medications had been an issue for as long as a year and noted it had not become noticeably worse in the last 3 months. Nurse #7 was aware of the facility 's procedure to order a controlled substance medication. When asked about the facility 's backup pharmacy, the nurse stated she had not utilized it.</p> <p>An interview was conducted on 3/1/17 at 2:20 PM with Nurse #9. Nurse #9 was identified as having</p>	F 425			

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F 425	<p>Continued From page 49</p> <p>borrowed a controlled substance medication from one resident to another on 4 occasions from 2/15/17 - 2/28/17 on the 400 Hall. During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents ' needs and the practice of borrowing medications from one resident to another. Nurse #9 reported the timely availability of medications has always been a problem, but it had gotten worse with the new pharmacy. The nurse reported she has been in-serviced to call the pharmacy when a medication was needed for a resident. Nurse #9 stated she understood the pharmacy may contact their backup pharmacy for medication delivery, if needed.</p> <p>An interview was conducted on 3/1/17 at 3:40 PM with Nurse #12. Nurse #12 was identified as having borrowed a controlled substance medication from one resident to another on 1 occasion from 2/15/17 - 2/28/17 on the 400 Hall. During the interview, Nurse #12 recalled borrowing the controlled substance medication. She indicated the resident was out of their medication and it was due to be given. Nurse #12 stated, "Yes, I did borrow it. Was it right? No." Nurse #12 indicated she has tried in the past to follow-up with the pharmacy to get the medications when needed, but this task has become even more difficult with the new pharmacy. Nurse #12 reported the availability of medications was not just a concern with controlled substances, but other meds as well.</p> <p>An interview was conducted on 3/1/17 at 4:15 PM with Nurse #10. Nurse #10 was identified as having borrowed a controlled substance medication from one resident to another on 4 occasions from 2/15/17 - 2/28/17 on the 400 Hall.</p>	F 425			

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F 425	<p>Continued From page 50</p> <p>During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents ' needs and the practice of borrowing medications from one resident to another. Upon review, the nurse confirmed her signature on the narcotic log. Nurse #10 stated she has since been made aware the practice of borrowing medications was no longer allowed. At this point, the nurse reported that if a resident was out of a controlled substance medication, she was supposed to look in the facility ' s new narcotic kit and sign out the medication, if available. Alternatively, Nurse #10 stated she could call the pharmacy to let them know when she needed a medication delivered.</p> <p>An interview was conducted on 3/1/17 at 4:35 PM with Nurse #1. Nurse #1 assumed responsibility as the Unit Manager. During the interview, Nurse #1 reported the new pharmacy typically made a "run" between 3:00-4:00 PM every day, and a "sweep run" (when the bulk of the medications would be delivered) between 3:00 and 6:00 AM daily. He also noted the pharmacy had arranged a back-up pharmacy for use on an as needed basis. However, he reported receipt of a medication from the back up pharmacy would typically take "at least 2 hours." Nurse #1 stated he was responsible for putting most of the pharmacy orders into the computer and faxing the scripts for controlled substances to the pharmacy. Although this process was typically completed by 5:00 PM or so, he noted the hall nurse was required to verify these orders and the pharmacy wouldn't see the medication orders until the nurse had approved them. Nurse #1 reported this verification of orders may be delayed and not be done until 10:00 PM or later due to the hall nurse ' s other duties related to</p>	F 425			

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F 425	<p>Continued From page 51 resident care.</p> <p>An interview was conducted on 3/2/17 at 6:55 AM with Nurse #13. Nurse #13 was identified as having borrowed a controlled substance medication from one resident to another on 2 occasions from 2/15/17 - 2/28/17 on the 400 Hall. During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents ' needs and the practice of borrowing medications. Upon review of the narcotic logs from the past 2 weeks, Nurse #13 identified her signature and acknowledged she borrowed medications (including controlled substances) from one resident to another if a resident was out of his/her medication and needed to receive it. She reported the facility had a new pharmacy the last few months and there have been "more issues" with medication availability than with the previous pharmacy. The nurse reported she has now been in-serviced regarding the facility policy which does not allow for the borrowing of controlled substances. The nurse stated she has been instructed to notify the pharmacy of any need for resident's medication. She reported the pharmacy was responsible to contact the back-up pharmacy, if needed, to deliver the medication.</p> <p>A telephone interview was conducted on 3/2/17 at 9:47 AM with the contract pharmacy ' s Customer Service and Account Manager. The Manager reported she was working with the facility ' s DON to identify several things that could help improve the timely availability of medications, including having the nurses become proactive when doing shift change and identifying medications that are getting low (before running out). Upon inquiry, the Manager reported the cut-off time for ordering</p>	F 425			

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F 425	<p>Continued From page 52</p> <p>medication refills was 3:00 PM and for new orders it was 5:00 PM Monday through Friday. The Manager reported medications were delivered nightly (leaving the pharmacy around 7:00 PM), with smaller runs and "mini-stat" runs that leave the pharmacy around 10:30 AM, 2:30 PM, and 1:00 AM. Upon inquiry, she stated the pharmacy did deliver on Saturday at the regular delivery time; and, on Sundays they utilized their after-hours protocol with the use of a backup pharmacy as needed. When the Manager was asked about the availability of controlled substance medications, she reported a hard script was needed for all controlled substances. However, she stated the prescription could be called in by the prescriber if the facility needed a Schedule III - V controlled substance medication. If a resident needed a Schedule II controlled substance medication and the physician called it in, the pharmacy had the ability to enact the emergency Drug Enforcement Agency (DEA) rule. The Account Manager stated, "We don't authorize any borrowing of controlled substances or any medications."</p> <p>A telephone interview was conducted on 3/2/17 at 10:41 AM with the facility 's consultant pharmacist. The pharmacist reported she had talked with the DON this week in regards to the borrowing of medications, and stated, "The issue is the medication is not there." He reported the pharmacy was working with the facility to figure out what the problems were in regards to the medications not being available when they were needed for a resident. When asked if he had previously identified a concern regarding the borrowing of medications (including controlled substances), he reported he had not. Upon inquiry, he reported the role of the consultant</p>	F 425			

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F 425	<p>Continued From page 53</p> <p>pharmacist during the transition to the new pharmacy included providing education and orienting staff to the pharmacy ' s policies and procedures. The pharmacist stated he was a point of contact to deal with issues such as medication dispensing and ordering, and to help coordinate whatever needed to be done.</p> <p>An interview was conducted on 3/2/17 at 1:45 PM with Nurse #3. Nurse #3 was identified as having borrowed a controlled substance medication from one resident to another on 7 occasions from 2/15/17 - 2/28/17 on the 400 Hall. The nurse confirmed her signature on the Narc log. Upon inquiry as to what circumstances prompted the nurse to borrow controlled substance medications from one resident to another, the nurse stated, "They (the residents) were out." Upon inquiry, the nurse stated she has since been in-serviced and informed the facility does not allow borrowing of medications from one resident to another. Nurse #3 reported she was instructed to call the pharmacy and request the medication, which may be sent via their back up pharmacy.</p> <p>An attempt was made to interview Nurse #18 by telephone on 3/3/17 at 8:57 AM. There was no answer so a message was left requesting a return call. Nurse #18 was identified as having borrowed a controlled substance medication from one resident to another on 1 occasion from 2/15/17 - 2/28/17 on the 400 Hall. Nurse #18 did not return the phone call.</p> <p>An interview was conducted on 3/3/17 at 11:45 AM with the facility ' s DON. During the interview, the DON discussed how the facility prepared for the pharmacy transition made on 12/1/16 to ensure resident medications continued to be</p>	F 425			

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F 425	Continued From page 54 received on a timely basis as needed. The DON reported the facility received emails informing them of the pharmacy transition, they had a pharmacy representative meet with 8-9 nurses prior to the transition date on general pharmacy issues, and the facility was provided written materials (including the pharmacy policies and procedures) on the day of the change to the new pharmacy. When asked what role the consultant pharmacist had during this transition, the DON reported he did not have a visible role in the facility during the transition period to the new pharmacy. Upon inquiry, the DON stated that her expectation was for every resident to have their medication in the facility, as ordered by the physician. A telephone interview was conducted on 3/3/17 at 1:25 PM with Nurse #5. Nurse #5 was no longer employed by the facility. The nurse was identified as having borrowed a controlled substance medication from one resident to another on 2 occasions from 2/15/17 - 2/28/17 on the 400 Hall. During the interview, inquiry was made in regards to the availability of controlled substance medications to meet the residents ' needs and the practice of borrowing medications from one resident to another. In regards to the borrowing of controlled substance medications, the nurse stated, "We have to do that quite often." Nurse #5 reported that when a medication was not available for a resident, she would sometimes go to another hall to find the correct dose of a medication so she could borrow it for the resident who was out.	F 425			
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		3/31/17	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 55</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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.</p> <p>(a) Procedures. 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>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. 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.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature</p>	F 431			

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F 431	<p>Continued From page 56</p> <p>controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) 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, pharmacist and staff interviews, the facility failed to: 1) Remove expired medications from 1 of 4 medication carts (300 hall med cart); 2) Store medications as specified by the manufacturer in 1 of 2 medication rooms (300/400 medication room); and 3) Label medications with the minimum labeling requirements in 1 of 4 medication carts (400 hall med cart).</p> <p>The findings included:</p> <p>1) An observation of the 300 Hall medication on 2/28/17 at 2:05 PM revealed an unopened vial of Lantus insulin (a long-acting insulin) labeled for use by Resident #109 was stored on the medication cart. The insulin was labeled as having been dispensed from the pharmacy on 1/23/17. No date was written on the outside container or insulin vial to indicate when it had been taken out of the refrigerator. Lantus insulin expires 28 days after opening or removal from refrigeration.</p> <p>A review of Resident #109 's February 2017</p>	F 431	<p>F-431 *Corrective action(s) taken for</p> <p>rsdt# 109, rsdt#8, and med cart/room.</p> <p>1. Rsd# 109's insulin was removed from the 300 hall medication cart and discarded by the 300 hall nurse on 2/28/17.</p> <p>2. Rsd# 8's eye gtts were removed and discarded from the south unit med room refrigerator by the ADON on 2/28/17.</p> <p>3. The medicine cup that contained unlabeled medications and the unlabeled Combivent inhaler were removed and</p>		

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F 431	<p>Continued From page 57</p> <p>physician orders revealed the resident had a current medication order for Lantus insulin to be injected subcutaneously (under the skin) every night at bedtime (revised on 1/21/17).</p> <p>An interview was conducted on 2/28/17 at 2:10 with Nurse #15. Upon inquiry, Nurse #15 reported the unopened insulin should have been stored in the refrigerator, not on the medication cart. She confirmed there was no indication as to when the insulin had been put on the medication cart.</p> <p>During an interview with the Director of Nursing (DON) on 3/1/17 at 9:30 AM, the DON indicated her expectation was for all unopened vials of insulin to be stored in the medication storeroom refrigerator until needed on the medication cart. Once a vial of insulin was opened, it should be dated. The DON specified that the facility 's policy was to discard opened vials of insulin 30 days from the date opened (or removed from the refrigerator).</p> <p>2) Accompanied by Nurse #1, an observation made of the 300/400 Medication Room on 2/28/17 at 1:55 PM revealed an unopened bottle of prednisolone acetate 1% ophthalmic suspension (a steroid eye drop) labeled for use by Resident #8 was stored in the refrigerator with a temperature of 41 degrees Fahrenheit. Pharmacy labeling on the bottle indicated the eye drops were dispensed from the pharmacy on 2/20/17. Manufacturer labeling on the bottle of the prednisolone acetate 1% ophthalmic suspension indicated the eye drops needed to be stored at 46 - 75 degrees Fahrenheit.</p> <p>A review of Resident #8 ' s February 2017</p>	F 431	<p>discarded from the 400 hall med cart by 400 hall nurse on 2/28/17.</p> <p>* Corrective actions taken for residents having potential to be affected by the same practice.</p> <p>1. A 100% audit was completed on the storage of medications on the 100, 200, 300, and 400 hall medication carts by the ADON on 2/28/17.</p> <p>2. A 100% audit was completed on the storage of medications in the north and south unit med rooms by the ADON on 2/28/17.</p> <p>*Corrective measures or systemic changes made to ensure that the deficient practice will not occur.</p> <p>1. Mandatory in-servicing was provided to all licensed nurses on medication storage by the DON and ADON. In-servicing included: Insulin storage,</p>		

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F 431	<p>Continued From page 58</p> <p>physician orders revealed the resident had a current medication order for prednisolone acetate 1% ophthalmic suspension to be instilled as 1 drop in the left eye twice daily for one week (start date 2/24/17).</p> <p>An interview was conducted with Nurse #1 on 2/28 at 2:27 PM. During the interview, Nurse #1 indicated he typically had not seen these eye drops in the refrigerator. He thought perhaps a 2nd or 3rd shift nurse may have inadvertently put them in the refrigerator.</p> <p>An interview was conducted on 3/1/17 at 9:30 AM with the facility ' s Director of Nursing (DON). The DON reported a nurse had moved medications from the other hallway to the 300/400 med room refrigerator on Monday (2/27/17) due to a replacement refrigerator being put into place on the 100/200 Hall. The DON thought this nurse must have inadvertently placed the eye drops in the refrigerator. Upon inquiry, the DON stated her expectation would be for medications to be stored appropriately.</p> <p>3) An observation of the 400 Hall medication on 2/28/17 at 1:25 PM revealed two -1 milligram (mg) warfarin tablets (an anticoagulant medication) and one - 1 milliliter (ml) vial of promethazine 25 mg/ml (an anti-nausea medication) were placed in a cup in the top drawer of the medication cart. The medications were not labeled with the minimum labeling requirements, including the resident ' s name or instructions. Upon further observation of the medication cart, a Combivent Respimat 20 micrograms (mcg) / 100 mcg per actuation inhalation spray canister (an inhalation medication used to treat chronic obstructive</p>	F 431	<p>eye gtt storage, and storage of meds in the facility that was completed on 3/30/17.</p> <p>2. An audit tool was created by the DON to monitor for appropriate storage of medication on the 100, 200, 300, and 400 hall medcarts, and the north and south med rooms that the DON, ADON, or alternate designee will complete.</p> <p>* Indicate how the facility will monitor performance.</p> <p>The DON will be responsible for compliance which will be achieved by the DON, ADON, or alternate designee auditing and monitoring the proper storage of medication in the facility.</p> <p>100 % audits will be completed by the DON, ADON, or alternate designee for the 100, 200, 300, 400 hall med carts and</p>		

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F 431	Continued From page 59 pulmonary disease or acute asthma) was lying in the bottom drawer of the cart. The medication was not labeled with the minimum labeling requirements, including the resident ' s name or instructions. An interview was conducted on 2/28 at 1:50 PM with Nurse #9. When asked if the medications found on the cart should be labeled, the nurse responded, "Of course it should." An interview was conducted on 3/1/17 at 9:30 AM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON stated her expectation would be for medications to be labeled and stored appropriately.	F 431	the north and south unit med rooms two times a week for four weeks and for four weeks and one time a week for eight weeks. QAPI will review monthly for three months.		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		3/31/17	

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F 441	Continued From page 60 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441			

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F 441	<p>Continued From page 61 spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to post a contact isolation sign outside a resident's door for one of one resident (Resident #119) on contact isolation precautions.</p> <p>Findings included:</p> <p>The facility policy entitled "Contact Precautions," effective June 2013 was reviewed. The policy stated "it is the intent of this facility to use contact precautions in addition to standard precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment." Procedures for contact precautions included "gloves should be worn when entering the room and while providing care for the resident" and "a gown should be donned prior to entering the room." The policy revealed that contact precautions may be considered for "multi drug resistant organisms (e.g., MRSA, VRE, ESBLs, Clostridium difficile)."</p> <p>1. Resident # 119 was re-admitted to the facility 3/2/17 with diagnoses that included urinary tract infection (UTI) due to extended-spectrum beta lactamase (ESBL) producing Escherichia coli and Clostridium difficile (C diff) colitis.</p> <p>An isolation cart was observed outside of Resident #119's room on 3/2/17 at 1:40 PM.</p>	F 441	<p>F-441 *Corrective action(s) taken for rsdt #119</p> <p>1. Sign identifying that rsdt was on contact isolation was placed outside of her room.</p> <p>2. The nurse involved in not obtaining a sign to notify that rsdt # 119 was on contact isolation was counseled and provided in-servicing on Village Care of King's contact isolation policy.</p> <p>* Corrective actions taken for residents having potential to be affected by the same practice.</p> <p>1. Audit was completed on all rsdts with current ordered isolation precautions.</p> <p>*Corrective measures or systemic</p>		

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F 441	<p>Continued From page 62</p> <p>There was no isolation sign posted on or near the door to the room.</p> <p>An isolation cart was observed outside of Resident #119's room on 3/2/17 at 2:00 PM. There was no isolation sign posted on or near the door to the room.</p> <p>On 3/2/17 at 2:15 PM Resident #119 was observed being admitted to the room. There was no isolation sign posted on or near the door to the room.</p> <p>A review of nurse's note dated 3/2/17 at 2:31 PM stated "Resident returned to facility via ambulance on stretcher at 2:15 on this day. Resident returned on contact precautions for c-diff and continuing antibiotic therapy (ABT)/UTI."</p> <p>A review of physician order dated 3/2/17 at 3:00 PM revealed "contact isolation every shift for ESBL/C-diff.</p> <p>On 3/2/17 at 3:02 PM Nurse Aide's #1 and #2 and the Admissions Director were observed entering Resident #119's room without implementing contact isolation precautions. There was no isolation sign posted on or near the door to the room.</p> <p>On 3/2/17 at 3:19 PM observed contact isolation sign posted on Resident #119's door.</p> <p>An interview was completed with the Infection Control Nurse on 3/2/17 at 3:05 PM during which she stated she had not yet received information about the isolation status of the resident. She reported the facility's process was the Admissions</p>	F 441	<p>changes made to ensure that the deficient practice will not occur.</p> <p>1. In-servicing was provided to all staff on Village Care of King's infection control policy.</p> <p>2. All nurses, admissions coordinator, social services, and all department heads were provided in-servicing on the notification process any rsdt noted to have ordered isolation precautions prior to admission of rsdt.</p> <p>Topics included: the notification of nursing administration, charge nurse, and hall staff by the admissions coordinator/ social services, the notification process by the unit manager of all department heads to communicate to their staff, obtaining the appropriate isolation precautions sign, PPE, and equipment, and appropriate isolation techniques.</p>		

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F 441	<p>Continued From page 63</p> <p>Director would notify staff of any admissions with contact precautions issues. The Infection Control Nurse stated she would be informed by her charge nurse. She stated whoever receives the order for contact isolation is responsible to post the isolation sign. During the interview the Infection Control Nurse called the admitting nurse (Nurse #2) who indicated she had received report from the hospital and got the isolation cart set up but did not post the isolation sign. The Infection Control Nurse stated the isolation signs were kept in a file cabinet at the nurse's station and also in the infection control office.</p> <p>Nurse Aide #1 was interviewed on 3/2/17 at 4:16 PM. She stated when a resident was admitted with isolation precaution orders, the floor nurse would get a report and notify the nurse aides of "what they need to wear, gloves, gown, mask, whatever they need." Nurse Aide #1 stated either the Infection Control Nurse or the floor nurse would place the isolation cart and post the sign. Nurse Aide #1 reported that Nurse #2 told her "resident was septic and most definitely go in with gloves." Nurse Aide #1 indicated she was given this information by the nurse prior to Resident #119's arrival. Nurse Aide #1 then reported she was told to only wear gloves "when coming into physical contact with the resident." She stated she entered resident's room to obtain weight and vitals and did not have to physically touch Resident #119 to complete the tasks.</p> <p>Nurse #1 was interviewed on 3/3/17 at 9:52 AM. He reported he was not assigned to care for Resident #119 on admission, but during the admissions process he typically put in all the orders for new admissions. He stated "most of the time the hospital doesn't send paperwork with</p>	F 441	<p>* Indicate how the facility will monitor performance. The DON will be responsible for compliance which is achieved by the DON or alternate designee monitoring for appropriate notification of nursing staff by admissions or social services of any rsdt identified to have orders to have isolation precautions prior to admission, appropriate isolation techniques provided by staff, obtaining appropriate isolation precaution sign, PPE, and equipment, and the notification of all department heads three times a week for four weeks and one time a week for four weeks. QAPI will review monthly for three months.</p>		

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F 441	<p>Continued From page 64</p> <p>contact isolation." He revealed he would look at the hospital discharge summary for anything that may trigger possible isolation and then would tell either the Infection Control Nurse or the hall nurse. He stated whoever took the order for contact isolation was responsible for placing the isolation cart outside of the resident's room and posting the isolation sign on the door. Nurse #1 stated he did not see the diagnosis on the hospital paperwork until after Resident #119 arrived. He indicated that staff were educated annually on contact precautions.</p> <p>An interview was completed with the Admissions Director on 3/3/17 at 10:03 AM. She reported her responsibility during the admissions process was she would receive the hospital discharge summary and would give it to Nurse #1 who would review the summary and stated anything that would indicate contact precautions would then be given to the Infection Control Nurse or the floor nurse.</p> <p>During an interview with Nurse #2 on 3/3/17 at 10:30 AM she stated when she gets a report from the hospital about contact isolation she would let the Infection Control nurse know; the floor nurse would put the isolation cart in place and the Infection Control nurse would post the isolation sign. Nurse #2 reported the hospital notified her that Resident #119 had C-diff but said nothing about contact isolation, however, she would still "treat it as contact precautions." She stated the sign not being on the door "that was my fault, I didn't know who had the contact sign, by the time I was looking for it she (Resident #119) came and I completely forgot. I take full responsibility."</p> <p>Nurse Aide #2 was interviewed on 3/3/17 at 11:05</p>	F 441			

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F 441	Continued From page 65 AM. She reported the nurse notifies her when a resident is on contact isolation precautions and what type of precautions. She stated it is the responsibility of nursing or housekeeping to put out the isolation cart but that sometimes the nurse aide will roll out the cart. "Most of the time when I come in the sign is already up, I assume it's whoever put the cart out." She reported she is educated at least every six months on contact precautions. Nurse Aide #2 stated the floor nurse had told her Resident #119 "was septic" and did not receive any other instructions at that time. She indicated the process for contact isolation would be to put gloves and a gown on before going into the room but stated she did not put these on because "we were just going in to do observation." An interview was completed with the Director of Nursing on 3/3/17 at 1:05 PM. She stated her expectation is that communication is made to staff when someone needs to be put on isolation and that the proper equipment and notifications are put into place.	F 441			
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 514			3/31/17

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F 514	<p>Continued From page 66</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and staff interviews, the facility failed to follow established procedures for the consistent and accurate documentation of the administration of controlled substance medications on the Medication Administration Record (MAR) and Controlled Medication Utilization Record for 2 of 4 sampled residents (Resident #122 and Resident #45) who received controlled substance medications on an as needed basis.</p> <p>The findings included:</p> <p>1) A review of the facility ' s policy on "General Dose Preparation and Medication Administration"</p>	F 514	<p>F-514 *Corrective action(s) taken for rsdt#122 and for rsdt #45</p> <p>1. Rsdt #122's electronic MAR and the rsdt's Ativan 0.5mg tab controlled medication administration inventory log that was provided by the pharmacy were audited by the DON on 3/17/17.</p>		

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NAME OF PROVIDER OR SUPPLIER VILLAGE CARE OF KING			STREET ADDRESS, CITY, STATE, ZIP CODE 440 INGRAM ROAD EXT BOX 1750 KING, NC 27021		
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F 514	<p>Continued From page 67 dated 12/1/07 (revised 5/1/10 and 1/1/13) included facility Procedures, which read, in part:</p> <p>6. "After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:</p> <p>6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN (as needed) medications, application sight) on appropriate forms ..."</p> <p>A review of Resident #122 ' s February 2017 medication orders included a current order for 0.5 milligrams (mg) lorazepam (an antianxiety medication) to be given as one tablet by mouth three times daily as needed for anxiety/agitation (initiated 9/5/16).</p> <p>A review of Resident #122 ' s February 2017 Medication Administration Record (MAR) revealed 15 doses of 0.5 mg lorazepam were documented as administered to the resident from 2/1/17 to 2/27/17. According to the MAR, a dose of lorazepam was given to the resident on the following dates and times: 2/1 at 5:56 AM; 2/3 at 5:41 PM; 2/4 at 7:47 PM; 2/7 at 4:20 PM; 2/8 at 1:02 AM; 2/8 at 8:41 PM; 2/13 at 12:08 PM; 2/14 at 12:46 AM; 2/14 at 4:48 PM; 2/15 at 4:33 PM; 2/16 at 1:23 AM; 2/16 at 7:47 PM; 2/19 at 12:47 AM; 2/22 at 7:52 PM; and, 2/24 at 2:40 AM.</p> <p>A review of Resident #122 ' s Controlled Medication Utilization Record (a declining inventory record of individual controlled substance medications stored on the medication cart for a resident; also known as a narcotic log)</p>	F 514	<p>2. Rsdtd #45's electronic MAR and the rsdt's lorazepam 1 mg controlled medication administration inventory log that was provided by the pharmacy were audited by the DON on 3/17/17.</p> <p>3. The nurses involved in the improper documentation of rsdt#122's and for rsdt #45's PRN narcotic administrations in which the noted nurses signed narcotics out on the rsdt's controlled inventory log and had not documented the administration the PRN medication of the electronic MAR were provided in-servicing on the facility's General Dose Preparation and Medication Administration policy that included the appropriate documentation of meds. The in-services were provided by the DON and the ADON. The in-services</p>		

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F 514	<p>Continued From page 68</p> <p>revealed 43 doses of 0.5 mg lorazepam were removed from the medication cart for the resident from 2/1/17 - 2/27/17. A dose of lorazepam was documented as removed from the medication cart for Resident #122 on each of the following dates and times: 2/1 at 6:00 AM; 2/1 at 5:00 PM; 2/2 at 9:00 PM; 2/3 at 4:00 PM; 2/4 at 9:00 AM; 2/4 at 9:00 PM; 2/5 at 9:00 AM; 2/5 at 8:00 PM; 2/7 at 10:00 AM; 2/7 at 4:14 PM; 2/8 at 1:00 AM; 2/8 at 8:36 PM; 2/9 at 7:00 PM 2/10 at 1:00 AM; 2/11 at 9:00 AM; 2/11 at 9:00 PM; 2/12 at 2:00 AM; 2/12 at 12:00 PM; 2/12 at 9:00 PM; 2/13 at 8:00 AM; 2/13 at 2:00 PM; 2/13 at 4:00 PM; 2/14 at 12:40 AM; 2/14 at 4:45 PM; 2/15 at 4:30 PM; 2/16 at 12:45 AM; 2/16 at 9:00 PM; 2/17 at 1:00 AM; 2/18 at 1:00 AM; 2/18 at 10:00 PM; 2/19 at 4:00 AM; 2/19 at 1:00 PM; 2/19 at 11:30 PM; 2/20 at 8:00 PM; 2/21 at 9:00 AM; 2/21 at 9:00 PM; 2/22 at 7:00 PM; 2/23 at 12:00 AM; 2/24 at 4:00 AM; 2/25 at 1:00 AM; 2/26 at 3:50 PM; 2/27 at 11:00 PM; and, 2/27 at 9:00 PM.</p> <p>An interview was conducted on 3/1/17 at 3:47 PM with Nurse #11. Nurse #11 was identified as having withdrawn 1 dose of 0.5 mg lorazepam labeled for Resident #122 ' s use (on 2/26) without documenting its administration to the resident on the MAR. During the interview, the nurse reviewed Resident #122 ' s narcotic log and MAR. The nurse was asked what procedures she employed for documenting the administration of controlled substances used on an as needed basis. Upon inquiry, Nurse #11 reported she first pulled the medication from the med cart, signed it out on the narcotic log, clicked on the computer icon to electronically record the medication was given, then administered the medication to the resident. The nurse stated she must not have clicked on the electronic record to record giving</p>	F 514	<p>were completed by 3/30/17.</p> <p>* Corrective actions taken for residents having potential to be affected by the same practice.</p> <p>1. A 100% audit for all rsdts who had MD orders for PRN narcotics were audited by the DON and ADON on 3/23/17.</p> <p>2. Med pass observations were completed on all nurses by the DON, ADON, or unit manger. All med pass observations were completed by 3/30/17.</p> <p>*Corrective measures or systemic changes made to ensure that the deficient practice will not occur.</p> <p>1. Mandatory in-servicing was provided to all nurses on the facility's General Dose Preparation and Medication Administration policy that</p>		

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F 514	<p>Continued From page 69 the medication to Resident #122.</p> <p>An interview was conducted on 3/1/17 at 4:00 PM with Nurse #4. Nurse #4 was identified as having withdrawn 3 doses of 0.5 mg lorazepam labeled for Resident #122 ' s use (on 2/2, 2/23, and 2/27) without documenting its administration to the resident on the MAR. During the interview, Nurse #4 reviewed the resident ' s narcotic log and MAR and verified her initials/signature on the forms. Upon further review of Resident #122 ' s MAR and Narcotic Log, the nurse acknowledged the MAR needed to indicate the resident received the "as needed" medication when it was signed out on the narcotic log. Nurse #4 stated, "I have to be more careful."</p> <p>An interview was conducted on 3/2/17 at 1:45 PM with Nurse #3. Nurse #3 was identified as having withdrawn 10 doses of 0.5 mg lorazepam labeled for Resident #122 ' s use (on 2/4, 2/5, 2/5, 2/11, 2/11, 2/12, 2/12, 2/18, 2/19, and 2/21) without documenting its administration to the resident on the MAR. During the interview, a review of Resident #122 ' s MAR and narcotic log was conducted and the nurse confirmed her initials/signature on the forms. When the nurse was asked about the documentation discrepancies between the narcotic log and the MAR for the administration of Resident #122 ' s lorazepam, the nurse stated she did not always chart on the MAR when "PRN" (as needed) medications were given. However, the nurse reported she always documented when scheduled medications were administered to a resident.</p> <p>An interview was conducted on 3/3/17 at 7:50 AM with Nurse #19. Nurse #19 was identified as</p>	F 514	<p>included the appropriate application of the policy's medication documentation guidelines. The in-services were provided by the DON and the ADON. The in-services were completed by 3/30/17. indicated.</p> <p>2. An audit tool was created by the DON to monitor the appropriate documentation of the administration of PRN narcotics.</p> <p>* Indicate how the facility will monitor performance.</p> <p>The DON will be responsible for compliance which is achieved by the DON, ADON, or alternate designee to monitor the facility policy guidelines on the documentation of PRNs that is outlined in the General Medication Preparation and Medication Administration policy by auditing the documentation of all</p>		

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

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F 514	<p>Continued From page 70</p> <p>having withdrawn 7 doses of 0.5 mg lorazepam labeled for Resident #122 ' s use (on 2/9, 2/10, 2/12, 2/17, 2/18, 2/25 and 2/27) without documenting its administration to the resident on the MAR. During the interview, Nurse #19 identified his signature/initials on the Resident #122 ' s narcotic log and MAR. Upon review, several medications were noted as having been signed out on the declining inventory sheet; however, they were not all recorded on the MAR as administered to the resident. When asked, the nurse stated his process was to immediately sign the medication out on the narcotic log when a controlled substance medication was taken from the cart. However, he acknowledged that sometimes he did not record the medication as given on the MAR after administration to the resident.</p> <p>An attempt was made to interview Nurse #18 by telephone on 3/3/17 at 8:57 AM. There was no answer so a message was left requesting a return call. Nurse #18 was identified as having withdrawn 3 doses of 0.5 mg lorazepam labeled for Resident #122 ' s use (on 2/7, 2/20, and 2/21) without documenting its administration to the resident on the MAR. Nurse #18 did not return the phone call.</p> <p>An attempt was made to interview Nurse #17 by telephone on 3/3/17 at 9:03 AM. There was no answer so a message was left requesting a return call. Nurse #17 was identified as having withdrawn 1 doses of 0.5 mg lorazepam labeled for Resident #122 ' s use (on 2/13) without documenting its administration to the resident on the MAR. Nurse #17 did not return the phone call.</p>	F 514	<p>PRN</p> <p>narcotics one time a week for 12 weeks.</p> <p>QAPI will review monthly for three months.</p>		

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F 514	<p>Continued From page 71</p> <p>An interview was conducted on 3/3/17 at 11:45 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated her expectation was that if a nurse gave a medication, it needed to be documented on the MAR. She also indicated a resident ' s narcotic log and MAR needed to correspond with one another as to when a medication was withdrawn from the cart and administered to the resident.</p> <p>A telephone interview was conducted on 3/3/17 at 1:25 PM with Nurse #5. Nurse #5 was no longer employed by the facility; however, she was identified as having withdrawn 3 doses of 0.5 mg lorazepam labeled for Resident #122 ' s use (on 2/1, 2/13 and 2/19) without documenting its administration to the resident on the MAR. When asked about discrepancies noted between Resident #122 ' s narcotic log and MAR for the controlled substance medication, the nurse stated the discrepancies may have been an oversight. Nurse #5 reported that she typically documented medications pulled from the cart, "right away, unless something came up."</p> <p>2) A review of the facility ' s policy on "General Dose Preparation and Medication Administration" dated 12/1/07 (revised 5/1/10 and 1/1/13) included facility Procedures, which read, in part:</p> <p>6. "After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:</p> <p>6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a mediation, if medications are refused, PRN (as needed) medications, application sight)</p>	F 514			

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F 514	<p>Continued From page 72 on appropriate forms ..."</p> <p>A review of Resident #45 ' s February 2017 medication orders included a current order for 1 milligram (mg) lorazepam (an antianxiety medication) to be given as one tablet by mouth as needed for sleep at bedtime (initiated 10/31/16).</p> <p>A review of Resident #45 ' s February 2017 Medication Administration Record (MAR) revealed 4 doses of 1 mg lorazepam were documented as administered to the resident from 2/5/17 to 2/27/17. According to the MAR, a dose of lorazepam was given to the resident on the following dates and times: 2/7 at 10:39 AM; 2/10 at 8:37 PM; 2/20 at 10:42 PM; and, 2/21 at 10:02 PM.</p> <p>A review of Resident #45 ' s Controlled Medication Utilization Record (a declining inventory record of individual controlled substance medications stored on the medication cart for a resident; also known as a narcotic log) revealed 11 doses of 1 mg lorazepam were removed from the medication cart for the resident from 2/5/17 - 2/27/17. A dose of lorazepam was documented as removed from the medication cart for Resident #45 on each of the following dates and times: 2/5 at 8:00 PM; 2/7 at 1:00 PM; 2/10 at 8:45 PM; 2/11 at 9:00 PM, 2/12 at 9:00 PM; 2/20 at 1:00 PM; 2/20 at 10:00 PM; 2/21 at 10:00 PM; 2/22 at 10:00 PM; 2/26 at 1:00 AM; and, 2/27 at 10:00 PM.</p> <p>An interview was conducted on 3/1/17 at 4:00 PM with Nurse #4. Nurse #4 was identified as having withdrawn 2 doses of 1 mg lorazepam labeled for Resident #45 ' s use (on 2/22 and 2/27) without documenting its administration to the resident on</p>	F 514			

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F 514	<p>Continued From page 73</p> <p>the MAR. During the interview, Nurse #4 reviewed the resident 's narcotic log and MAR and verified her initials/signature on the forms. Upon review of Resident #45 ' s MAR and Narcotic Log, the nurse acknowledged the MAR needed to indicate the resident received the "as needed" medication when it was signed out on the narcotic log. Nurse #4 stated, "I have to be more careful."</p> <p>An interview was conducted on 3/2/17 at 1:45 PM with Nurse #3. Nurse #3 was identified as having withdrawn 3 doses of 1 mg lorazepam labeled for Resident #45 ' s use (on 2/5, 2/11, and 2/12) without documenting its administration to the resident on the MAR. During the interview, a review of Resident #45 ' s MAR and narcotic log was conducted and the nurse confirmed her initials/signature on the forms. When the nurse was asked about the documentation discrepancies between the narcotic log and the MAR for the administration of Resident #45 ' s lorazepam, the nurse stated she did not always chart on the MAR when "PRN" (as needed) medications were given. However, the nurse reported she always documented when scheduled medications were administered to a resident.</p> <p>An interview was conducted on 3/3/17 at 7:50 AM with Nurse #19. Nurse #19 was identified as having withdrawn 1 dose of 1 mg lorazepam labeled for Resident #45 ' s use (on 2/26) without documenting its administration to the resident on the MAR. During the interview, Nurse #19 identified his signature/initials on the Resident #45 ' s narcotic log and MAR. Upon review, it was noted that a dose of lorazepam had been signed out on the declining inventory sheet;</p>	F 514			

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F 514	<p>Continued From page 74</p> <p>however, the medication was not recorded on the MAR as having been administered to the resident. When asked, the nurse stated his process was to immediately sign the medication out on the narcotic log when a controlled substance medication was taken from the cart. However, he acknowledged that sometimes he did not record the medication as given on the MAR after administration to the resident.</p> <p>An attempt was made to interview Nurse #18 by telephone on 3/3/17 at 8:57 AM. There was no answer so a message was left requesting a return call. Nurse #18 was identified as having withdrawn 1 dose of 1 mg lorazepam labeled for Resident #45 ' s use (on 2/20) without documenting its administration to the resident on the MAR. Nurse #18 did not return the phone call.</p> <p>An interview was conducted on 3/3/17 at 11:45 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated her expectation was that if a nurse gave a medication, it needed to be documented on the MAR. She also indicated a resident ' s narcotic log and MAR needed to correspond with one another as to when a medication was withdrawn from the cart and administered to the resident.</p>	F 514			