STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 04/18/2019

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ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

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E 000	Initial Comments An unannounced Recertification and Complaint Survey was conducted on 04/15/19 through 04/18/19. The facility was found in compliance with the requirments CFR 483.73. Emergency Preparedness. Event ID OTFI11.	E 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to accurately code a resident for Level II PASRR (Preadmission Screening and Resident Review) on the most recent comprehensive Minimum Data Set for 1 of 2 resident sampled for PASRR (Resident #53). Findings included: Resident #53 was re-admitted to the facility on 04/22/15 with diagnoses which included chronic kidney disease, chronic obstructive lung disease, type 2 diabetes, congestive heart failure, high blood pressure, weakness, anxiety and depression. A review of a listing of residents who had PASRR provided by the facility indicated Resident #53 had a Level II PASRR. A review of the most recent annual Minimum Data Set (MDS) dated 04/03/19 indicated Resident #53 was cognitively intact for daily decision making. The MDS also revealed	F 641	1. MDS was corrected for resident #53 on 5/6/19. 2. All residents with a Level II PASRR were audited on 4/17/19 by the Clinical Reimbursement Coordinator (CRC)to assure coded correctly on the most recent MDS. All necessary corrections will be completed by 5/10/19. 3. Center Executive Director re-educated Director of Social Services on 4/17/19 to assure residents with a Level II PASSR are coded correctly on each resident's MDS. 4. CRC will audit MDS Assessments for resident's with a Level II PASSR 1 x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month to assure MDS coded correctly. Findings of audit will be reviewed and addressed by Performance Improvement Committee 1 x monthly x 3 months and on-going as	5/16/19

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

Electronically Signed | 05/10/2019

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F 641	Continued From page 1 Resident #53 was independent with bed mobility, transfers, eating and hygiene but required extensive assistance with dressing and toileting. A section labeled PASRR Level II indicated "no." An interview on 04/18/19 at 2:59 PM with the Clinical Reimbursement Coordinator (CRC) she verified she was responsible for doing the MDS. She confirmed the PASRR information pulled from the Social Services assessment questions that were completed by the Social Worker. After review of the Social Services questions in the computer system she verified the Social Worker had indicated no to the Level II PASRR question. She stated the question for Level II PASRR should have been checked as yes to indicate Resident #53 was a Level II PASRR. She explained the Social Worker was new to the facility. The CRC stated she had signed off on Section A of the MDS and she took responsibility for the error. An interview on 04/18/19 at 3:24 PM with the Social Worker revealed she had only worked in the facility since February 2019. She confirmed Resident #53 had a Level II PASRR with a start date of 01/03/13. She explained the MDS was a new process for her and she had some on-line training but had not had anyone train her about the process. An interview on 04/18/19 at 3:59 PM with the Administrator revealed it was her expectation for the MDS to be coded accurately and to the best of their ability. She confirmed the CRC signed off on the MDS and she was unaware Resident #53 had a Level II PASRR.	F 641	needed.	
F 658	Services Provided Meet Professional Standards	F 658		5/16/19

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F 658 SS=D	Continued From page 2 CFR(s): 483.21(b)(3)(i) §483.21(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 by: Based on record review, staff interview, and Nurse Practitioner interview the facility failed to administer a narcotic pain medication as prescribed for 1 of 2 residents sampled during narcotic reconciliation during medication storage (Resident #55). The findings included: Resident #55 was admitted to the facility on 05/27/16 and most recently readmitted on 04/19/18. Resident #55's diagnoses included low back pain, osteoarthritis, chronic pain syndrome, and polyarthritis. Review of a physician order dated 12/08/17 read, Lyrica (pain medication used to treat neuropathy) 50 milligrams (mg) by mouth 3 times a day. Review of the most recent quarterly Minimum Data Set (MDS) dated 04/05/19 revealed that Resident #55 was cognitively intact and was independent with activities of daily living. The MDS further revealed that Resident #55 received scheduled pain medication and non-medication intervention for pain. The assessment further revealed that pain was reported by Resident #55 occasionally of a 3 on a pain scale during the assessment reference period.	F 658	1. On 4/17/19, resident #55 was assessed by hall nurse to assure no adverse affects d/t not receiving pain medication. 2. On 5/7/19, the cards containing narcotics in all medication carts were audited by hall LPNs and an LPN Unit Manager to assure controlled narcotic reconciliation correct. Nurse #1 was re-educated by the Nurse Practice Educator on 5/1/19 to assure medications are given as ordered and signed out of narcotic book accordingly. 3. Nurses were re-educated on 4/26/19, 5/1/19 & 5/7/19 by the Nurse Practice Educator (NPE)to assure medications are given as ordered and signed out of narcotic book accordingly. All newly hired nurses will be educated by hall staff, Nurse Practice Educator and/or LPN Unit Managers during the orientation period to assure medications are given as ordered and signed out of narcotic book accordingly. 4. The (CNE), the Unit Managers and/or the NPE will audit cards containing narcotics in all medication carts 1 x	

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F 658	Continued From page 3 During a narcotic reconciliation with Nurse #1 on 04/17/19 at 3:34 PM of the 100-hall medication cart it was discovered that Resident #55's individual record of Lyrica indicated she had 7 tablets, but her card of Lyrica tablets contained 8. An interview was conducted with Nurse #1 on 04/17/19 at 3:36 PM. Nurse #1 stated that she must have signed out the narcotic and forgot to get it out of the narcotic drawer when she was preparing and administering Resident #55's lunch time medications. Nurse #1 stated, "that was all me I just forgot to administer the medication after I signed out for it." Nurse #1 indicated this was a medication error and she would immediately notify the Director of Nursing (DON) and the Medical Doctor (MD). A telephone conversation was conducted with Nurse #1 and the MD on 04/17/19 at 3:39 PM. Nurse #1 informed the MD that she had not administered Resident #55's lunch time Lyrica as ordered. The MD indicated that Nurse #1 should just administer the next scheduled dose of Lyrica. An interview was conducted with the Nurse Practitioner (NP) on 04/18/19 at 12:34 PM. The NP stated that she expected medications to be given as ordered unless the nurse had questions or concerns with the medication. She added that in that case the Nurse should contact the medical provider to share her concerns and take any additional orders. An interview was conducted with the DON on 04/18/19 at 3:41 PM. The DON stated that she expected Nurse #1 to sign out the narcotic in the hard-bound narcotic book after the medication was administered and not before that way	F 658	weekly x 4 weeks then 2 x monthly x 1 month then 1 x monthly x 1 month to assure controlled narcotic reconciliation correct. Findings of audit will be reviewed and addressed by Performance Improvement Committee 1 x monthly x 3 months and on-going as needed.	

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F 658	Continued From page 4 ensuring the controlled narcotic reconciliation was always accurate. She added that Nurse #1 had reported the controlled narcotic count was not correct to her and the investigation had been initiated. The DON stated that she expected ordered medications to be administered as prescribed. An interview was conducted with the Administrator on 04/18/19 at 4:22 PM. The Administrator stated she always expected the controlled narcotic count to be correct and the for the nursing staff to sign out the controlled narcotics after the medication was administered to ensure a correct reconciliation at all times.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		5/16/19

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F 690	Continued From page 5 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and Nurse Practitioner interviews the facility failed to provide proper urinary catheter care by not using a cleanser for 1 of 2 residents (Resident #44) reviewed for indwelling urinary catheter. The findings included: Resident #44 was admitted to the facility 10/22/13 with diagnoses that included cerebral vascular accident and neuromuscular dysfunction of the bladder. A review of Resident #44's medical record revealed an order dated 03/18/14 for an indwelling urinary catheter to bedside drainage for neuromuscular bladder dysfunction. A review of a Care Plan dated 10/02/18 indicated Resident #44 required an indwelling catheter due to a neurogenic bladder with a goal to have no signs or symptoms of a urinary tract infection. The interventions included to provide catheter	F 690	1. On 4/17/19, resident #44 was assessed by hall LPN to assure no adverse affects related to inappropriate catheter care. 2. On 5/9/19, all residents with indwelling catheters were audited by Nurse Practice Educator to assure soap and/or peri-wash available at bedside. 3. CNAs were re-educated on 4/18/19 & 5/9/19 by the Nurse Practice Educator(NPE)to assure appropriate peri-care being provided for all residents with indwelling catheters. Newly hired CNAs will be observed during orientation period by Nurse Practice Educator with completion of competency/skills checklist for all residents with indwelling catheters. 4. The (CNE), the Unit Managers and/or the NPE will observe one CNA per hall performing catheter care 1 x weekly x 1	

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F 690	Continued From page 6 care after each incontinent episode. A review of Resident #44's quarterly Minimum Data Set (MDS) assessment dated 03/31/19 revealed she had severe cognitive impairment and she required extensive to total assistance with her activities of daily living. The MDS also indicated Resident #44 was always incontinent of bowel and had an indwelling urinary catheter. A review of the medical record (urine culture and sensitivity) dated 04/12/19 revealed Resident #44 had a urinary tract infection of a pseudomonas aeruginosa bacteria. The medical record also indicated the urinary tract infection was treated with a 7 day course of an antibiotic. On 04/17/19 at 3:33 PM Nurse Aide (NA) #1 and NA #2 went in to provide catheter care for Resident #44. NA #1 wet 4 wash cloths from the sink and brought them to Resident #44's bedside and laid the wet wash clothes on her over bed table. Both aides positioned the resident on her back and released the resident's brief. NA #1 then used 3 wet wash cloths to perform catheter care carefully wiping from the insertion site down the catheter tubing but did not use soap or periwash (cleanser) during the procedure. After the procedure NA #1 was asked if she had forgotten anything and she admitted she had performed Resident #44's catheter care without using soap or periwash because she forgot it. On 04/17/19 at 4:21 PM during an interview with Nurse #3 she stated she expected the Nurse Aide #1 and #2 to have gathered all of the supplies needed for catheter care before they began Resident #44's catheter care and if they had done that they would not have forgotten the periwash.	F 690	month then 2 x monthly x 1 month then 1 x monthly x 1 month to assure providing appropriate catheter care. Findings of audit will be reviewed and addressed by Performance Improvement Committee 1 x monthly x 3 months and on-going as needed.	

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F 690	Continued From page 7 On 04/18/19 12:53 PM an interview was conducted with the Nurse Practitioner (NP) who stated she expected the staff to use periwash when performing catheter care on Resident #44 because she was prone to have frequent urinary tract infections. During an interview with the Director of Nursing (DON) on 04/18/19 at 4:06 PM she stated her expectation would be that NA #1 and #2 gathered all of the supplies required in order to perform proper catheter care. The DON added, had the aides gathered all the supplies beforehand, they would have had the periwash and performed the catheter care appropriately.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to administer oxygen at 2 liters per minute (Resident #55) and failed to change oxygen tubing weekly as ordered (Resident #30) for 2 of 4 residents reviewed for respiratory care . The findings included:	F 695	1. The oxygen for resident #55 was adjusted to 2L on 4/17/19 and the tubing was changed for resident #30 on 4/17/19. 2. The oxygen settings for all residents with orders for oxygen was audited by the Center Nurse Executive and the Unit Managers on 4/17/19 to assure settings	5/16/19

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F 695	Continued From page 8 Resident #55 was admitted to the facility on 05/15/15 with diagnoses which included chronic obstructive pulmonary disease (COPD). Review of Resident #55's medical record revealed an order for continuous oxygen at 2 liters per minute (l/m) dated 05/03/18. Review of Resident #55's recent quarterly Minimum Data Set (MDS) dated 04/04/19 revealed moderately impaired cognition and she required extensive assistance with most of her activities of daily living. The MDS also indicated she required oxygen. Review of Resident #55's Medication Administration Record (MAR) for April 2019 revealed an order for continuous oxygen to be delivered at 2 l/m. The order was initialed twice a day (12 hour shifts) every day for 04/15/19, 04/16/19 and 04/17/19 by the nurse. Review of Resident #55's Care Plan (CP) dated 04/17/19 revealed she was at risk for respiratory complications related to her diagnoses of COPD. The CP indicated she would have no signs or systems of respiratory distress by utilizing interventions which included providing oxygen at 2 l/m via nasal cannula. On 04/15/19 at 11:01 AM during the initial interview with Resident #55, her oxygen concentrator was set to deliver oxygen at 1.5 l/m via nasal cannula. Subsequent observations of the oxygen delivery were: -04/16/19 at 1:57 PM oxygen delivery was set at 1.5 l/m -04/17/19 at 9:28 AM oxygen delivery was set at	F 695	correct based on MD orders. All oxygen tubing for residents with orders for oxygen was audited on 4/17/19 by Center Nurse Executive and Unit Managers to assure dated appropriately and was changed as needed. 3. All nurses were re-educated on 4/26/19,5/1/19 & 5/7/19 by the Nurse Practice Educator on how to assure oxygen settings are correct on an oxygen concentrator and that all oxygen tubing is to be changed out weekly. Newly hired nurses will be observed and/or educated by the Nurse Practice Educator during orientation period with completion of competency/skills checklist for all residents with orders for oxygen therapy to assure oxygen settings are correct on an oxygen concentrator and that all oxygen tubing is to be changed out weekly. 4. The (CNE), the Unit Managers and/or the NPE will audit oxygen concentrators and oxygen equipment to assure settings appropriate and/or tubing has been changed out timely 1 x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month. Findings of audits will be reviewed and addressed by Performance Improvement Committee 1 x monthly x 3 months and on-going as needed.	

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F 695	Continued From page 9	F 695		

1.5 l/m
-04/17/19 at 12:19 PM oxygen delivery was set at 1.5 l/m
and at no time during the observations did Resident #55 show signs of shortness of breath or difficulty breathing.

During an interview with the Director of Nursing (DON) on 04/18/19 at 4:10 PM, she stated that she looked at Resident #55's oxygen setting the evening of 04/17/19 and discovered the setting was not on the 2 liters ordered by the physician and adjusted the oxygen to the correct setting of 2 l/m. The DON also stated she expected the nurses to check all of the resident's oxygen setting twice a day to assure the oxygen setting was on the correct amount as ordered by the physician.

2. Resident #30 admitted to the facility on 04/03/13 and most recently readmitted to the facility on 09/22/15. Resident #30's diagnoses included: chronic obstructive pulmonary disease, heart failure, and others.

Review of a physician order dated 09/30/15 read, change oxygen tubing every Wednesday night.

Review of the most recent quarterly minimum data set (MDS) dated 03/15/19 revealed that Resident #30 was moderately impaired for daily decision making and required extensive assistance with most activities of daily living. The MDS further revealed that Resident #30 had 6 months or less to live, received hospice care and required oxygen during the assessment reference

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F 695	Continued From page 10	F 695		

period.

Review of the Treatment Administration Record (TAR) dated 04/01/19 through 04/30/19 revealed that the oxygen tubing was last changed on 04/10/19 by Nurse #4.

An observation of Resident #30 was made on 04/15/19 at 11:40 AM. Resident #30 was up in her chair at bed. She was alert and verbal and had an oxygen cannula in her nose. There was an oxygen concentrator next to her chair that was set to deliver 2 liters per minute via the cannula. The oxygen tubing was dated 04/03/19, the water bottle on the concentrator was dated 04/03/19, and the bag attached to the concentrator to hold the tubing was dated 04/03/19.

An observation of Resident #30 was made on 04/16/19 at 10:07 AM. Resident #30 was resting in bed with her eyes open. She was alert and verbal. She had an oxygen cannula in her nose. Next to Resident #30's bed was an oxygen concentrator that was set to deliver 2 liters per minute via the cannula. The oxygen tubing was dated 04/03/19, the water bottle on the concentrator was dated 04/03/19, and the bag attached to the concentrator to hold the tubing was dated 04/03/19.

An observation of Resident #30 was made on 04/17/19 at 9:10 AM. Resident #30 was resting in bed with her eyes open. She was alert and verbal. She had an oxygen cannula in her nose. Next to Resident #30's bed was an oxygen concentrator that was set to deliver 2 liters per minute via the cannula. The oxygen tubing was dated 04/03/19, the water bottle on the concentrator was dated 04/03/19, and the bag

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F 695	Continued From page 11	F 695		

attached to the concentrator to hold the tubing was dated 04/03/19.

An interview was conducted with Nurse #1 on 04/17/19 at 2:41 PM. Nurse #1 confirmed that she routinely cared for Resident #30. Nurse #1 stated that she routinely checked oxygen concentrator's once a shift to ensure that the setting was correct. Nurse #1 stated that she did not check the dates of the oxygen tubing or water bottles. She added those were changed weekly on Wednesday's nights.

An interview was conducted with the Director of Nursing (DON) on 04/17/19 at 4:11 PM. The DON confirmed that she had changed Resident #30's oxygen tubing earlier in the day and that it had been dated 04/03/19. She added that the water bottle and bag all contained the date of 04/03/19 so she replaced the entire set up including oxygen tubing, water bottle, and bag.

An interview was conducted with Nurse #4 on 04/17/19 at 4:55 PM. Nurse #4 stated that she had been working at the facility for approximately 5 weeks and worked 7:00 PM to 7:00 AM. She stated that each Wednesday night she was prompted to change all the oxygen tubing, water bottles, and bags on her units. Nurse #4 stated that each week she changed the same 3 residents oxygen tubing including Resident #30. Nurse #4 could not explain why the oxygen tubing, water bottle, and bag all contained the date of 04/03/19 and not 04/10/19. She stated "maybe I just put the wrong date" but was not for sure why the equipment was still dated 04/03/19.

A follow up interview was conducted with the DON on 04/18/19 at 3:41 PM. The stated that she

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F 695	Continued From page 12 expected the nurses to check the oxygen concentrators every shift and if they saw a date that was a week past then they should change the equipment out for new equipment. The DON further stated that she expected the oxygen tubing, water bottle and bag to changed and dated every week as ordered.	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		5/16/19

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F 755	Continued From page 13 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to keep an accurate reconciliation of controlled narcotic medications in the hard-bound narcotic reconciliation book for 2 of 2 medications cart reviewed during medication storage. This affected 2 residents (Resident #55 and Resident #45). The facility also failed to keep controlled narcotic medications stored in their original packaging for 1 of 2 medications cart reviewed during medication storage (100-hall medication cart). The findings included: 1. Resident #55 was admitted to the facility on 05/27/16 and most recently readmitted on 04/19/18. Resident #55's diagnoses included low back pain, osteoarthritis, chronic pain syndrome, and polyarthritis. Review of a physician order dated 12/08/17 read, Lyrica (pain medication used to treat neuropathy) 50 milligrams (mg) by mouth 3 times a day. Review of the most recent quarterly Minimum Data Set (MDS) dated 04/05/19 revealed that Resident #55 received scheduled pain medication and non-medication intervention for pain. The assessment further revealed that pain was reported by Resident #55 occasionally of a 3 on a pain scale during the assessment reference period. During a narcotic reconciliation with Nurse #1 on	F 755	1. On 4/17/19, resident #55 was assessed by hall LPN to assure no adverse affects d/t failing to receive prescribed medication. Resident #45 did not request medication therefore was in no distress. After investigation it was determined which resident was prescribed the Lorazepam found in the narcotic drawer. The resident was assessed on 4/17/19 by hall LPN to assure no adverse affects from failing to received prescribed medication. 2. On 5/7/19, the cards containing narcotics in all medication carts were audited by Unit Managers& hall LPNs to assure controlled narcotic reconciliation correct. Nurse #1 and #2 were re-educated by the Nurse Practice Educator on 5/1/19 to assure medications are given as ordered and signed out of narcotic book accordingly. After investigation it was determined which nurse dropped Lorazepam in narcotic drawer and was unaware. This nurse was re-educated on the appropriate way remove medication from pill card (blister pack)to prevent reoccurrence. 3. Nurses were re-educated on 4/26/19, 5/1/19 & 5/7/19 by the Nurse Practice Educator (NPE)to assure medications are given as ordered, medications are removed from pill card appropriately and	

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F 755	Continued From page 14 04/17/19 at 3:34 PM of the 100-hall medication cart it was discovered that Resident #55's individual record of Lyrica indicated she had 7 tablets, but her card of Lyrica tablets contained 8. An interview was conducted with Nurse #1 on 04/17/19 at 3:36 PM. Nurse #1 stated that she must have signed out the narcotic and forgot to get it out of the narcotic drawer when she was preparing and administering Resident #55's lunch time medications. Nurse #1 stated, "that was all me I just forgot to administer the medication after I signed out for it." An interview was conducted with the Consultant Pharmacist (CP) on 04/18/19 at 2:17 PM. The CP indicated he visited the facility once a month. He added that on his visits he generally did not reconcile the narcotic medications and indicated that the staff should be reconciling the controlled narcotic medications at the beginning and end of their shift. The CP stated that if the controlled narcotic count was not correct the facility should determine the cause and if they needed assistance in doing so could reach out to the pharmacy for assistance. The CP indicated that he expected the controlled narcotic medication reconciliation to always be accurate. An interview was conducted with the Director of Nursing (DON) on 04/18/19 at 3:41 PM. The DON stated that she expected the nurses to count their controlled narcotic medication at the beginning and end of their shift and any time they had any concerns or issues. The DON stated that the controlled narcotic was signed out in the hard bound narcotic book after the medication was administered and not before that way ensuring the controlled narcotic reconciliation was always	F 755	signed out of narcotic book accordingly. Newly hired nurses will be educated and observed during orientation by Nurse Practice Educator, hall nurse and/or Unit Managers to assure medications are given as ordered, medications are removed from pill card appropriately and signed out of narcotic book accordingly. 4. The (CNE), the Unit Managers and/or the NPE will audit cards containing narcotics and narcotic storage in all medication carts 1 x weekly x 4 weeks then 2 x monthly x 1 month then 1 x monthly x 1 month to assure controlled narcotic reconciliation correct and no loose narcotics in storage area. Findings of audit will be reviewed and addressed by Performance Improvement Committee 1 x monthly x 3 months and on-going as needed.	

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accurate. She added that Nurse #1 had reported the controlled narcotic count was not correct to her and the investigation had been initiated.

An interview was conducted with the Administrator on 04/18/19 at 4:22 PM. The Administrator stated she always expected the controlled narcotic count to be correct and the for the nursing staff to sign out the controlled narcotics after the medication was administered to ensure a correct reconciliation at all times.

2. During a narcotic reconciliation with Nurse #1 on 04/17/189 at 3:34 PM of the 100-hall medication cart a small round white tablet that contained EP 904 printed on one side of the tablet loose in the bottom of the controlled narcotic drawer of the medication cart was found. Further investigation revealed that the small round white tablet was Lorazepam 50 milligrams (mg).

An interview was conducted with Nurse #1 on 04/17/19 at 3:36 PM. Nurse #1 confirmed that the small round white tablet that was found loose in the controlled narcotic drawer of the medication cart was Lorazepam 50 mg but could not identify who it belonged too. The other Lorazepam located in the controlled narcotic drawer reconciled correctly. Nurse #1 further confirmed that she had counted the narcotics at the beginning of her shift but had not inspected the drawer, she stated that "they just count the tablets and cards." Nurse #1 reported the loose and unaccounted for narcotic to the Director of Nursing (DON).

An interview was conducted with the Consultant Pharmacist (CP) on 04/18/19 at 2:17 PM. The CP

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indicated he visited the facility one a month. He added that on his visits he generally did not reconcile the narcotic medications and indicated that the staff should be reconciling the controlled narcotic medications at the beginning and end of their shift. The CP indicated that he expected all narcotics to be accounted for and should not be loose in the bottom of the narcotic drawer.

An interview was conducted with the DON on 04/18/19 at 3:41 PM. The DON stated that she expected the nurses to count their controlled narcotic medication at the beginning and end of their shift and any time they had any concerns or issues. The DON stated that she expected all narcotics to be accounted for and they should not be loose in the bottom of the narcotic drawer. She added that Nurse #1 had reported the loose Lorazepam that was found during reconciliation and she had begun the investigation.

3. Resident #45 was admitted to the facility on 07/24/15 and most recently readmitted on 11/29/16. Resident #45's diagnoses included polyneuropathy, osteoarthritis, and pain in left knee.

Review of a physician order dated 10/03/17 read, Oxycodone (narcotic pain medication) 20 milligrams (mg) by mouth as needed for pain.

Review of the most recent quarterly Minimum Data Set (MDS) dated 03/31/19 revealed that Resident #45 received scheduled and as needed pain medication along with non-medication pain intervention. Resident #45 reported pain frequently of a 7 on a pain scale during the assessment reference period.

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During a narcotic reconciliation with Nurse #2 on 04/18/19 at 2:58 PM of the 400-hall medication cart it was discovered that Resident #45's individual record of Oxycodone indicated he had 28 tablets, but his card of Oxycodone contained 29.

An interview was conducted with Nurse #2 on 04/18/19 at 3:00 PM. Nurse #2 stated that she was used to Resident #45 asking for the Oxycodone and she signed it out in error while preparing and administering his medications. She stated that Resident #45 had not requested a Oxycodone during the medication pass.

An interview was conducted with the Consultant Pharmacist (CP) on 04/18/19 at 2:17 PM. The CP indicated he visited the facility one a month. He added that on his visits he generally did not reconcile the narcotic medications and indicated that the staff should be reconciling the controlled narcotic medications at the beginning and end of their shift. The CP stated that if the controlled narcotic count was not correct the facility should determine the cause and if they needed assistance in doing so could reach out to the pharmacy for assistance. The CP indicated that he expected the controlled narcotic medication reconciliation to always be accurate.

An interview was conducted with the DON on 04/18/19 at 3:41 PM. The DON stated that she expected the nurses to count their controlled narcotic medication at the beginning and end of their shift and any time they had any concerns or issues. The DON stated that the controlled narcotic was signed out in hard bound narcotic book after the medication was administered and not before that way ensuring the controlled

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F 755	Continued From page 18 narcotic reconciliation was always accurate. An interview was conducted with the Administrator on 04/18/19 at 4:22 PM. The Administrator stated she always expected the controlled narcotic count to be correct and the for the nursing staff to sign out the controlled narcotics after the medication was administered to ensure a correct reconciliation at all times.	F 755		