STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: ______ B. WING ______	C 09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Forsyth County Department of Social Services conducted a complaint investigation on 8/31/16 and 9/01/16.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to attend to personal care needs for 3 of 3 sampled residents (Residents #1, #2, and #3) in the Memory Care Unit (MCU) who were unable to attend to for themselves. The findings are: A. Review of Resident #2's current FL-2 dated 07/07/16 revealed: -Diagnoses included dementia and weakness. -The resident was assessed as incontinent of bowel and bladder. -The resident required extensive assistance with bathing, feeding, and dressing. Review of Resident #2's Resident Register revealed she was admitted to the facility on 05/05/12.	D 269		

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D 269	Continued From page 1 Review of Resident #2's current care plan dated 07/07/16 revealed: -The care plan did not include an assessment date. -The care plan was signed by the physician on 07/07/16. -Documentation "Resident requires extensive assistance with her ADLs" (Activities of Daily Living). -Resident #2 was assessed as having "daily incontinence" of bowel and bladder. -Under the section for Toileting, was documented "staff routinely clean". Continuous observation on 09/01/16 from 8:00 am to 11:15 am revealed: -At 8:00 am, Resident #2 was seated in her wheelchair in the dining room eating breakfast. -At 8:45 am, Resident #2 propelled herself in the wheelchair to the activity room. -At 10:10 am, staff took Resident #2 to the dining room for snack. -At 10:35 am, Resident #2 propelled herself in the wheelchair back to the activity room. -At 11:15 am, after prompting by surveyor, Staff A, Personal Care Aide (PCA), took Resident #2 to her room to provide incontinent care. -Resident #2 was not checked by any staff for incontinence during the continuous observation from 8:00 am until 11:15 am. Interview on 09/01/16 at 11:05 am with Staff A revealed: -She was the assigned caregiver for Resident #2 today. -The night shift staff got Resident #2 out of bed and dressed for the day before the end of their shift at 7:00 am. -The facility policy for incontinence checks was	D 269		

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D 269	Continued From page 2 either 15 or 30 minutes. -Staff A routinely checked all her assigned residents for incontinence every 15 to 30 minutes throughout her shift. -Staff A did not physically check Resident #2 for incontinence this morning during the continuous observation period because "you can ask" Resident #2 whether or not she was wet; "besides, she'll tell you she has to go". Observation on 09/01/16 at 11:15 am revealed: -Staff A asked Resident #2 if she needed to go to the bathroom. The resident replied, "No". -Staff A asked Resident #2 if she would try (to use the bathroom) for her and the resident replied, "Okay". -Staff A pushed Resident #2 in her wheelchair to the bathroom and transferred her to the toilet, during which time the resident stated, "I'm done wet, I'm done wet'. -Observation of the pull-up removed from the resident revealed it was saturated with urine and there was separation and clumping of the pull-up material inside the lining. -Staff A told the resident, "You done peed about twice in that". -Surveyor was unable to visualize Resident #2's skin condition at this time. Interview on 09/01/16 at 9:46 am with Resident #2's family member revealed: -The family member lived in another state and had only been able to visit the resident once since she was admitted to the facility. -The family member visited the resident "a few months ago" and did not find any issues with the resident's care at that visit. Based on review of Resident #2's record and interviews with staff, it was determined Resident	D 269		

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#3 was not interviewable.

Refer to interview on 09/01/16 at 10:39 am with a Personal Care Aide (PCA).

Refer to interview on 09/01/16 at 2:35 pm with a second PCA.

Refer to interview on 09/01/16 at 11:22 am with a third PCA.

Refer to interview on 09/01/16 at 11:54 am with the Administrator.

Refer to interview on 09/01/16 at 12:36 am with the Resident Care Director (RCD).

B. Review of Resident #3's current FL-2 dated 04/06/16 revealed:
-Diagnoses included dementia and physical debility.
-The resident was assessed as incontinent of bowel and bladder.
-The resident was "TD" (total dependence) for bathing, feeding, and dressing.

Review of Resident #3's Resident Register revealed she was admitted to the facility on 05/06/14.

Review of Resident #3's current care plan dated 04/06/16 revealed:
-The care plan did not include an assessment date.
-The care plan was signed by the physician on 04/06/16.
-Resident #3 was assessed as having "daily incontinence" of bowel and bladder.
-Resident #3 was assessed as "always disoriented", "significant" memory loss, and as

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having "no speech".
-Under the section for Toileting, was documented "totally dependent" and "staff toilet change Q2H" (every two hours).

Continuous observation on 09/01/16 from 8:00 am to 11:15 am revealed:
-At 8:00 am, Resident #3 was seated in the dining room.
-At 8:51 am, staff pushed Resident #3 in her wheelchair to the activity room. The resident was leaning in the wheelchair to the right with her legs crossed, her head was propped up by her right hand and her right elbow was on the arm of the wheelchair.
-At 9:40 am, Resident #3's position was unchanged.
-At 10:10, Resident #3 was alone in the activity room as the other residents had been taken to the dining room for snack.
-After inquiring by surveyor, staff retrieved Resident #3 from the activity room and took her to the dining room for snack.
-At 10:32 am, staff pushed Resident #3 in her wheelchair from the dining room back to the activity room.
-At 11:27 am, after prompting by surveyor, Staff B, Personal Care Aide (PCA), took Resident #3 to her room to provide incontinent care.
-Resident #3 was not checked by any staff for incontinence during the continuous observation from 8:00 am until 11:27 am.

Interview on 09/01/16 at 11:22 am with Staff B revealed:
-He was the assigned caregiver for Resident #3 today.
-Staff B was working extra today and began his shift at 9:00 am this morning.
-Staff B routinely checked his assigned residents

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every 15 or 30 minutes for incontinence.
-"I just guess at when it's time (to check the residents for incontinence). You just know. It's just a sense".
-He did not check Resident #3 for incontinence this morning because time went by fast, then it was time for snack, and he had been busy helping shave other residents and making beds.
-Staff B stated he would check Resident #3 now.

Observation on 09/01/16 at 11:27 am revealed:
-Staff B pushed Resident #3 in her wheelchair to her room for incontinent care.
-Resident #3 was seated in the wheelchair with her legs crossed.
-Staff B placed his hands under the resident's arms and lifted her body from the wheelchair and laid her on the bed.
-Throughout the transfer, Resident #3 remained bent at the hips with her legs crossed.
-Staff B uncrossed the resident's legs and lifted her clothing to provide incontinent care.
-Staff B was wearing 2 pull-ups.
-The outside pullup did not appear to be wet; the inside pullup was saturated with urine.
-Staff B stated he did not know the resident had on 2 pullups.
-When asked, Staff B stated he guessed staff used 2 pullups so when they could take off the inside one and they would already have the other one on.
-Observation of Resident #3's skin did not reveal any overly reddened areas or skin breakdown.

Interview on 09/01/16 at 11:05 with a PCA revealed the night shift staff got Resident #3 out of bed and dressed for the day before the end of their shift at 7:00 am.

Based on review of Resident #3's record and

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interviews with staff, it was determined Resident #3 was not interviewable.

Refer to interview on 09/01/16 at 10:39 am with a Personal Care Aide (PCA).

Refer to interview on 09/01/16 at 2:35 pm with a second PCA.

Refer to interview on 09/01/16 at 11:22 am with a third PCA.

Refer to interview on 09/01/16 at 11:54 am with the Administrator.

Refer to interview on 09/01/16 at 12:36 am with the Resident Care Director (RCD).

C. Review of Resident #1's current FL-2 revealed:
-Diagnoses included dementia, congestive heart failure, and coronary artery disease.
-Documentation the resident was continent of bowel and bladder.

Review of Resident #1's Resident Register revealed she was admitted to the facility on 06/24/16.

Review of Resident #1's record revealed there was no care plan in the resident's record.

Review of Resident #1's care plan provided later by the Resident Care Director (RCD) revealed:
-The care plan did not include an assessment date or a signature of the person who performed the assessment.
-The care plan was signed by the physician today, 09/01/16.
-Under the section for Social/Mental Health

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History was documented, "Family stated resident doesn't like to get up to early ask him if he says no go back to him later and check on him [sic].
-Resident #1 was assessed as having "normal" bowel and bladder.
-Resident #1 was assessed as "sometimes disoriented" and "forgetful-needs reminders".
-Under the section for Toileting, was documented "limited assistance" and "staff will check Q2H (every two hours) and assist with toileting".

Interview on 08/31/16 at 4:00 pm with Resident #1's family member revealed:
-Resident #1 required assistance from staff for "everything".
-Resident #1 was frequently incontinent without realizing it.
-Sometimes when the family member visited, she found the resident wet and could "smell urine on him".
-Resident #1 had been told by the urologist to go to the bathroom every two hours whether he needed to or not, but the resident did not understand.
-Resident #1 was "not changed often enough" and sometimes he was embarrassed when he realized he was wet.
-Resident #1 was "always a very, very clean man and showered every day", but often was "left in his pajamas" now.
-"I think by 10:00 (am), he should be got up and dressed if he's not up already."
-The family member stated she felt the facility provided good care and she had no concerns other than the "wetting".

Continuous observation on 09/01/16 from 8:00 am to 11:15 am revealed:
-At 8:00 am, Resident #1 was lying in his bed. The resident's door was ajar approximately 2-3

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D 269	Continued From page 8 inches. -At 8:45 am, Resident #1's position in bed was unchanged; no staff had entered the resident's room or looked into the room. -At 9:06 am, Resident #1 ambulated independently to the bathroom and back to his bed. -At 9:10 am, the housekeeping and laundry Manager took paper towels and toilet paper into Resident #1's bathroom and closed the resident's door upon exit. -At 9:17 am, a laundry staff person was going room to room gathering clothes and clothes hangers, passed over Resident #1's room and continued to the next room. -At 9:49 am, a housekeeper entered Resident #1's room, exited and spoke with a Staff B, Personal Care Aide (PCA), in the hallway and asked Staff B to come to Resident #1's room. -Resident #1 was observed to be lying diagonally in bed under the covers with his head hanging off the mattress on one side and his feet hanging off the mattress on the other side. -Staff B straightened the resident in the bed and asked him if he wanted a shave. The resident's response was inaudible to surveyor. -Staff B did not pull back the covers to check the resident for incontinence. -At 9:53 am, Staff B left the resident's room. -At 10:07 am, the nurse from a home health agency entered Resident #1's room. -At 10:17 am, the home health nurse peeked out of the room and asked the housekeeper to get a staff person to assist her with the resident. -At 10:23 am, a Personal Care Aide (PCA) entered the room. -At 10:28 am, the PCA exited the room. Interview on 09/01/16 at 10:30 am with the home health nurse revealed:	D 269		

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-Today was her first visit with Resident #1.
-The nurse requested a PCA to come to the room in order to get some information about the resident.
-The PCA provided incontinent care for Resident #1 while she was in the room.
-Resident #1 was "a little wet" when the PCA checked him.

Interview on 09/01/16 at 11:05 am with Staff A, PCA, revealed:
-She was the assigned caregiver for Resident #1 today.
-The facility policy for incontinence checks was either 15 or 30 minutes.
-Staff A routinely checked all her assigned residents for incontinence every 15 to 30 minutes throughout her shift.
-She "just changed" Resident #1.
-She checked Resident #1 when she "first came in" at 7:00 am and again before breakfast.
-Resident #1 "goes to the bathroom himself the majority of the time, but in between, we do check".

Based on review of Resident #1's record, interviews with staff, and attempted interview with Resident #1, it was determined Resident #1 was not interviewable.

Refer to interview on 09/01/16 at 10:39 am with a Personal Care Aide (PCA).

Refer to interview on 09/01/16 at 2:35 pm with a second PCA.

Refer to interview on 09/01/16 at 11:22 am with a third PCA.

Refer to interview on 09/01/16 at 11:54 am with

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the Administrator.

Refer to interview on 09/01/16 at 12:36 am with the Resident Care Director (RCD).

____

Interview on 09/01/16 at 10:39 am with a Personal Care Aide (PCA) revealed:
-"I think" incontinence rounds are every two hours, and some are checked every hour, but "I do mine every 30 minutes".
-"It's really every two hours but I check mine all day."

Interview on 09/01/16 at 2:35 pm with a second PCA revealed:
-Her routinely assigned group of residents were "mostly on 15-minute checks".
-Some residents were on 30-minute checks.
-The 15 or 30 minute checks were not just for supervision but for incontinence as well, meaning they were supposed to be checked to see if they were wet every 15-30 minutes.
-"I know which ones are my wetters and I know which ones won't always tell you the truth if you ask if they are wet."

Interview on 09/01/16 at 11:22 am with a third PCA revealed:
-He routinely checked his assigned residents every 15 or 30 minutes for incontinence.
-"I just guess at when it's time (to check the residents for incontinence). You just know. It's just a sense".

Interview on 09/01/16 at 11:54 am with the Administrator revealed:
-The facility policy for incontinence checks on residents was every two hours.
-Incontinence rounds were occasionally increased if needed by the Resident Care

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D 269	Continued From page 11 Director (RCD) on a case-by-case basis. -The 15-minute and 30-minute checks were for increased supervision needs only, not incontinence checks. -It would be "impossible" to check all incontinent residents every 15-30 minutes. Interview on 09/01/16 at 12:36 pm with the Resident Care Director (RCD) revealed: -The facility policy for incontinence rounds was every two hours. -The 15-minute and 30-minute checks were for residents who required increased supervision, not for incontinence checks. -The RCD was not aware staff were not checking the residents for incontinence every two hours. -There was no place to document every 2 hour checks, as the PCA logs only had designated spaces to document three times per shift. -There was currently no system in place for monitoring to ensure residents were checked for incontinence every two hours.	D 269		
D936	10A NCAC 13F .1010 (d) (e) Pharmaceutical Services 10A NCAC 13F .1010(d) Pharmaceutical Services (d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the	D936		

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D936	Continued From page 12 medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions: (1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident ' s absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence; (2) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication ' s release from the facility and shall include at least: (A) the name and strength of the medication; (B) the directions for administration as prescribed by the resident's physician; (C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence; (3) The resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and (4) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container. The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and	D936		

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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) COMPLETE DATE
D936	Continued From page 13 returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications ' release from and return to the facility. (e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to provide pharmaceutical services to assure accurate records of the receipt, use and disposition of medications were maintained in the facility and readily available for review for 3 of 3 residents (Resident #4, #8, and #9) that used an outside pharmacy. The findings are: A. Review of Resident #4's current FL2 dated 6/17/16 revealed: -Diagnoses of Schizophrenia, right knee joint replacement, hypertension, unilateral primary arthritis, and hypomagnesemia. -Physician orders for cortef (ant-inflammatory) 12.5mg every morning and 2.5mg every evening, divalproex acid (mood stabilizer) 250mg every evening, Exelon Patch (enhances memory) 9.5 mg/hr daily, furosemide (treats fluid retention) 20mg on Monday, Wednesday and Friday, multivitamin (supplement) one tablet daily, Namenda (treats dementia) 28 XR every evening, aspirin (mild pain reliever) 325mg once daily, magnesium (supplement) 400mg twice daily. Resident #4's medications were not available for	D936		

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	HAL034098	A. BUILDING: ______ B. WING ______	C 09/01/2016

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review due to Resident #4 discharged on 8/26/16.

Review of Resident #4's Medication Release form dated 8/26/16 revealed:
-The following medications were released for Resident #4 one tablet of furosemide 20mg, 22 tablets of divalproex acid 250mg, 25 Exelon patches and 105 tablets of the multivitamin.
-There were 5 pre-packaged multi-dose medication packs labeled as morning medications.
-There were 4 pre-packaged medication packs labeled as evening medications.
-The form was signed by a Medication Aide (MA) and the Responsible Party (RP).

Interview with Resident #4's RP on 8/31/16 at 2:42 pm revealed:
-Her family member dropped off all of Resident 4's medications on 8/04/16.
-They obtained all of Resident #4's medications from an outside pharmacy.
-When they brought the Resident #4's medications to the facility they gave them to a MA.
-The MA did not record what medications they received from Resident #4's RP.
-The RP had an issue with magnesium having been used too quickly so the RP started recording what medications, how much they delivered to the facility and the name of the MA that received the medications.
-The facility staff had contacted the family and requested they bring Resident #4's medications because the facility ran out of the medications.
-The facility ran out of Resident #4's medications 13 days earlier than they should have.
-The facility called the family back and had found Resident #4's medication and cancelled the request for refills.

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-When Resident #4 was discharged from the facility on 8/26/16, the RP thought the facility had not utilized the medications as ordered by the physician because they had not used enough based on the dates on the package.

Refer to interview on 9/01/16 at 10:32 am with a first shift MA.

Refer to interview on 9/01/16 at 3:04 pm with the Resident Care Director (RCD).

Refer to interview on 9/01/16 at 12:10 pm with the Administrator.

B. Review of Resident #8's current FL2 dated 5/27/16 revealed:
-Diagnoses of chronic obstructive pulmonary disease, anemia, bronchitis, diabetes mellitus, osteoporosis, asthma, endometrial cancer and depression.
-Physician orders for lisinopril (anti-hypertensive) 2.5mg 1 tablets daily, multivitamin (supplement) 1 tablet on Monday, Wednesday and Friday, milk of magnesia (laxative) 30 cc every morning, fluticasone nasal spray (treats seasonal allergies) 1 spray into each nostril daily, esomeprazole (reduces stomach acid) 20mg, Spiriva (prevents bronchospasms) 18 mcg 1 inhale daily, montelukast (prevents wheezing) 10mg 1 tablet daily, Senna (laxative) 8.6mg 2 tablets daily, aspirin (mild pain reliever) 81mg 1 tablet daily and calcium with vitamin D and K (supplement) 1 tablet at 12:00 pm.

Observation of Resident #8's on medication on hand revealed all ordered medications were present, labeled and current.

Interview with Resident #8's Responsible Party

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(RP) on 9/01/16 at 11:25 am revealed:
-Resident #8's prescription medications were obtained through a mail order company and the over the counter medications were purchased at a local pharmacy and she brought them all in to the facility.
-The RP had all the prescription medications on auto-refill and received notifications from the mail order company when they were being refilled and mailed.
-She often received telephone requests from a MA at the faclity requesting medications that she had already delivered.
-Most of the time the MAs failed to look in the medication room for the medications they requested.
-She did not know the exact dates of these requests, but it happened on several occasions.
-The facility staff did not keep a record of the medications that she dropped off so she started to keep a very accurate record of what medications she had dropped off, how many and with who because the MAs called for requested medications far earlier than they should.

Refer to interview on 9/01/16 at 10:32 am with a first shift MA.

Refer to interview on 9/01/16 at 3:04 pm with the Resident Care Director (RCD).

Refer to interview on 9/01/16 at 12:10 pm with the Administrator.

C. Review of Resident #9's current FL2 dated 7/18/16 revealed:
-Diastolic heart failure, insomnia, dysphagia, chronic obstructive pulmonary disease, spinal stenosis, Parkinson's Disease, hyperlipidemia, urinary retention, gastroesophageal reflux

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disease, anemia, angina and chronic pain.
-Physician orders for Eliquis (blood thinner) 2.5mg 1 tablet twice daily, docusate sodium (stool softener) 100mg 1 tablet daily, oxycodone (moderate to severe pain reliever)10mg 1 tablets every 4 hours as needed for pain for 14 days, Lyrica (anti-convulsant)100mg 2 tablets at night, albuterol 90 mcg inhaler 2 puffs every 4 hours as needed for wheezing or shortness of breath, amitriptyline (anti-depressant) 50mg 1 tablet every night, dexilant (treats acid reflux) 60mg 1 tablet every day, fluticasone (used for seasonal allergies) 50 cg 1 spray in each nostril as needed, hydrochlorothiazide (anti-hypertensive) 12.5mg 1 tablet daily, levothyroxine (thyroid hormone replacement) 75mcg 1 tablet daily, multivitamin (supplement) 1 tablet daily, nitrostat .3mg 1 sublingually every 5 minutes as needed for chest pain and if no relief after 3 doses call physician.

Observation of Resident #9's on medication on hand revealed all ordered medications were present, labeled and current.

Interview with Resident #9's Responisble Party (RP) on 9/01/16 at 12:58 pm revealed:
-The RP visited the facility last week and two Mediation Aides (MAs) approached her about needing Resident #9's Lyrica.
-The RP told both of the MAs that the Lyrica had one refill and to re-order from the pharmacy she used.
-The MAs called it into a different local pharmacy and the RP was required to go pick up the medication and deliver it to the facility.
-The RP dropped the medication off and the facility staff did not have her sign anything to indicate the medication had been delivered and recieved.
-She did not think the facility kept a record of the

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D936	Continued From page 18 medications that she dropped off. Refer to interview on 9/01/16 at 10:32 am with a first shift MA. Refer to interview on 9/01/16 at 3:04 pm with the Resident Care Director (RCD). Refer to interview on 9/01/16 at 12:10 pm with the Administrator. _______________ Interview on 9/01/16 at 10:32 am with a first shift MA revealed: -The facility used one of two pharmacies and there were only a few residents that used outside pharmacies. -The medications delivered were checked off individually by the MA that received the medication tote. -The facility staff would keep a record of the medications that were received by the pharmacy, they recorded medications administered and recorded the medications that were returned back to the pharmacy. -The facility staff would not keep a record of the medications that were brought in by the RPs or outside pharmacies. Interview on 9/01/16 at 3:04 pm with the Resident Care Director (RCD) revealed: -The facility did not have a policy for recording medications that were supplied by the RPs. -The staff used to have a policy that accounted for all medications including those supplied by the RPs. -She did not know why the staff stopped using that policy but knew the staff did not account for medications that were brought in from outside pharmacies.	D936		

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D936	Continued From page 19 Interview on 9/01/16 at 12:10 pm with the Administrator revealed: -The facility did have a policy for accounting for all of the medications they received from their contracted pharmacy. -Medications were checked and signed in indiviudally by the MA on duty. One copy of the reciept was sent to the pharmacy and the other was maintained in the facility files. -The staff did not record medications that were brought in to the facility by RPs from outside pharmacies. -She was going to contact the Regional Nurse and obtain a policy for recording the medications received by RPs from outside pharmacies.	D936		