<table>
<thead>
<tr>
<th>(K4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS=B</td>
<td>&lt;483.00(u), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
</tr>
</tbody>
</table>

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

---

All PRN (as needed medications) records and Narcotic count down sheets for residents, will be audited by the Director of Nursing, Unit Coordinator's, Medical Records and Staff Development Coordinator for accuracy, and were corrected by Licensed Nurse and/or Certified Medication Aide immediately. Licensed Nurse 1 and 2 along with Certified Medication Aide 1 and 2 were in-serviced 1:1 and disciplinary action was given.

New PRN (as needed medication sheets) were put in place to eliminate duplicate documentation and improve accuracy.

The Director of Nursing, Staff Development Coordinator, Unit Coordinators and Medical Records are auditing records every other day on a ongoing/permanent basis for any discrepancies, 100% of all Medication Administration records, PRN (as needed medication records and Narcotic count down sheets) are audited.
The facility realizes the potential for this alleged deficient practice could affect other residents. Staff Development, Unit coordinators, and Medical Records will report to Director of Nursing with findings for further intervention or disciplinary action if needed.

Director of Nursing or Administrator will prepare and submit a summary for OAPI meeting monthly, for any further intervention needed.
Continued From page 2

A. Medication Aide #2 documented on 04/09/13 at 01:00 PM on the declining inventory record that he administered 2 oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered.

B. Nurse #4 documented on 04/12/13 at 02:30 PM on the declining inventory record that she administered 2 oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered.

C. Nurse #3 documented on 04/14/13 at 02:30 AM on the declining inventory record that she administered 2 oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered.

D. Nurse #3 documented on 04/14/13 at 05:00 PM on the declining inventory record that she administered 2 oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered.

Nurse #4 was not available for interview during the survey.

An interview with Medication Aide #2 on 04/16/13 at 04:01 PM revealed he was responsible for administering PRN medications on 04/08/13 for Resident #4. He stated that the expectation was to document administration of all PRN medications by placing his initials on the front of the MAR; then to document the date, time, and name, strength, and dose of medication, reason for administration and the effectiveness of the medication on the back of the MAR. Medication Aide #2 stated that controlled narcotics should
Continued From page 3
also be documented on the declining inventory record and that the documentation should match in all three places. Medication Aide # 2 confirmed that he gave the medication as he had documented on the declining inventory record but missed documenting on the front and back of the MAR on 04/08/13 at 01:00 PM. Medication Aide # 2 acknowledged that the importance of documenting appropriately ensures the safety of the resident to receive the correct medications.

An interview with Nurse #3 on 04/16/13 04:11 PM revealed she was responsible for administering PRN medications on 04/14/13 for Resident #4. She stated that the expectation was to document administration of all PRN medications by placing her initials on the front of the MAR, then to document the date, time, and name, strength, dose of medication, reason for administration and the effectiveness of the medication on the back of the MAR. Nurse #3 stated that controlled narcotics should also be documented on the declining inventory record and that the documentation should match in all three places. Nurse #3 confirmed that she gave the medications as she had documented on the declining inventory record but missed documenting on the front and back of the MAR on 04/14/13 at 02:30 AM and 05:00 PM. Nurse #3 acknowledged that the importance of documenting appropriately ensures the safety of the resident to receive the correct medications.

An interview with the Director of Nursing (DON) on 04/16/13 at 04:35 PM revealed she expected staff to document administration of all PRN medications by placing their initials on the front of the MAR; then to document the date, time, name,