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WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

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F 431 SS=J	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, and	F 431	Past noncompliance: no plan of	7/1/16

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

Electronically Signed | 07/01/2016

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F 431	Continued From page 1 staff interviews, the facility failed to secure medications in a locked compartment to prevent 1 of 3 residents with wandering and hoarding behaviors from obtaining those medications, hiding them in his room and self-administering two of the pills. (Resident #4) Findings included: Resident #4 was admitted to the facility on 1/11/16 with diagnoses which included: Chronic atrial fibrillation, coronary artery disease, diabetes mellitus; and, altered mental status with psychosis related to urinary tract infection, and agitation. Review of the quarterly Minimum Data Set (MDS) dated 4/15/16 indicated Resident #4 was cognitively intact; had no mood or behaviors problems; required supervision with transfers, walking, and locomotion; and, used a wheelchair for mobility. A Physician's Note dated 5/26/16 revealed Resident #4 was delusional with some paranoia. Review of the Nurse's Note dated 6/7/16 revealed Resident #4 propelled himself throughout the facility in his wheelchair, but would ambulate in his room without his walker. Review of a Nurse's Statement dated 6/12/16, revealed Resident #4 attempted to go through a locked medication cart. During an interview on 6/17/16 at 10:33am, the Administrator revealed a resident (Resident #4) took a bag of medications which were just delivered from the Pharmacy on the night shift of	F 431	correction required.	

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6/10/16-6/11/16. The bag of medications had been placed on the bottom counter at the nurse's station. She stated that the nurse had turned away from the bag of medications on the counter and was doing something at the medication cart (before counting the medications), when the resident had "swiped" the bag of medications. The bag of medications was recovered. The Physician was notified and an investigation was completed by the DCS (Director of Clinical Services). The resident was physically fine. The staff was in-serviced and audits were done. The Administrator also revealed the resident was currently in the hospital for psychological evaluation due to behaviors.

The Nurse's Note dated 6/14/16 at 3:00pm, indicated the facility received a telephone order from the Physician for Resident #4 to be sent out to the hospital due to being a danger to self, other residents, and staff. The resident's family and the psychiatry services were notified.

During an interview on 6/17/16 at 10:44am, the DCS revealed Resident #4 exhibited wandering behaviors and had to be closely watched because he wandered into other residents' rooms and the laundry room, would remove items and take them to his room. The DCS stated during the night of the incident, bags of medications were delivered to the front hall nursing station by the Pharmacy between 11:00pm (6/10/16) and 1:00am (6/11/16). There were two nurses in the building (front hall nurse and the back hall nurse). Both nurses received bags of medications at the delivery and the front hall nurse signed the delivery ticket. The front hall nurse, SN#1 (Staff Nurse) placed her bag of medications on the bottom counter of the nurse's station then turned

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her back, when she turned back around she did not notice the medications were missing. The DCS indicated she assumed SN#1 forgot that she had not put the medications in the medication storage room. The DCS then revealed on Monday morning (6/13/16), one of the housekeepers was cleaning Resident #4's room when she noticed a stack of medications in the resident's drawer of his nightstand as she was putting something of his in the drawer. The housekeeper immediately reported the observation to her Supervisor who reported it to the Administrator. The Administrator directed a nurse (did not recall which nurse) to remove all of the medications found in the resident's room. The DCS revealed SN#2 began neurological checks and began assessing Resident #4 every four hours. During the assessment SN#2 asked the resident where did he get all of the medications found in his room and the resident responded the Physician ordered them for him. When SN#2 asked if he had ingested any of the medications, the resident told her he took one green pill on Saturday and one green pill on Sunday. The DCS stated she and the Unit Manager checked the bubble pack/card containing the green colored pills and noted two 360mg (milligram) each of diltiazem (heart medication) were missing. The DCS revealed Resident #4 had an order for 300mg diltiazem scheduled everyday. She also noted during the investigation the resident was alert and verbal, propeling himself in hallway. The Physician and the resident's RP (responsible party) were notified. The DCS called the facility's Regional Director of Clinical Services who advised/assisted her (DCS) in developing an Action Plan. The DCS stated the Action Plan included: counseling and disciplinary action for SN#1; attempted to draw labs on the resident, but

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he refused; a medication error/variance was completed; inserviced all facility nurses on the proper way to handle medications; immediately had the Pharmacy fax over a list of medications with the residents' names then inventoried every medication that had been delivered from the pharmacy from June 3, 2016 to June 13, 2016 (all medications were accounted for); DCS had and would continue to: monitor delivery and handling of medications at night and document this on an Audit Sheet twice a week for twelve weeks; and, audit Pharmacy delivery three times a week for twelve weeks.

On 6/17/16 at 12:07pm, the Administrator stated all of these Action Plans would be reviewed during the facility's QA (Quality Assurance) meeting which was held monthly.

During a telephone interview on 6/18/16 at 7:29am, SN#1 stated she had worked at the facility for over six years during third shift. She indicated the Pharmacy delivered medications to the facility between 10:45pm and 11:15pm every night; but she could not recall if Resident #4 was present during any of those deliveries because he was always in and out of his room throughout the night. She indicated she was not made aware Resident #4 had to be closely monitored or that he had a habit of taking items not belonging to him. SN#1 revealed the first time she was made aware of missing medications was when the DCS notified her on 6/13/16 that the "cleaning lady" found a bag of medications in Resident #4's room and that she (SN#1) was the one who signed the pharmacy delivery slip. SN#1 indicated on 6/10/16 the pharmacy delivered bags of medications (could not recall the number of bags) between 10:45pm-11:15pm. She stated "there

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was a lot going on during this time (giving report and shift change)". SN#1 revealed two nurses were required to sign for the medications (the narcotics as well as the other bags of medications). SN#1 stated that she and probably the second shift nurse signed for the medications, if delivery was during the shift change. SN#1 recalled turning away from the counter of the nurse's station to immediately place the narcotics in the locked box on the medication cart while the other bags of medications were lying on the top counter of the nurse's station. She indicated there was usually more than one bag of medications to be locked in the medication storage room and she assumed that was the situation that night; therefore, she would not have known a bag of medication was missing because the number of bags were not counted at the time of delivery. SN#1 revealed as a result of this incident, she received a written warning; was inserviced on the importance of how to check the delivery of medications and not allowing them out of sight; and, the DCS conducted an observation of a medication delivery and storage of medications during her (SN#1) shift.

During an interview on 6/18/16 at 1:57pm, HS#1 (Housekeeping Staff) accompanied by the Housekeeping Supervisor revealed while she was cleaning Resident #4's room on 6/13/16 at approximately 8:30am, the resident was in his wheelchair in his room. HS#1 stated she observed several bubble packs of medications (approximately 4-5 packs) peeking out from under the resident's bib (clothing protector) which he had on his lap. She stated when she asked the resident what was under the bib, the resident responded "this is my medicine" then, the resident began placing the packets in the top

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drawer of his nightstand. HS#1 stated she asked if there were pills in the packs and the resident's response was "yes". HS#1 revealed she immediately left the resident's room and reported the finding to her Supervisor. HS#1 and her Supervisor returned to the resident's room (Resident #4 was no longer in the room). HS#1 indicated the Housekeeping Supervisor opened the drawer of the nightstand and also observed the packs of medications. The Housekeeping Supervisor revealed housekeeping staff were not allowed to touch medications. Both were unsure of the number of bubble medication packs/cards that were in the drawer. The Housekeeping Supervisor stated he reported the finding to SN#2 who also observed the medications in the drawer of the nightstand. HS#1 and her Supervisor left the resident's room and reported the finding to the Administrator.

Review of a written statement by SN#2 dated 6/13/16, revealed she was called to Resident #4's room at approximately 8:30am on 6/13/16 by the housekeeping manager. She observed ten packages/cards of facility medication belonging to various residents in the drawer of the Resident #4's nightstand. After searching, no other medications were found in the resident's room. The Unit Manager was notified and the room was again searched. The resident's vital signs and neurological checks were obtained and were within normal limits. The resident's behaviors were unchanged from morning. The every fifteen minute checks for changes in the resident's behavior remained in place.

On 6/18/16 at 5:09pm, an interview was conducted with SN#2. This nurse provided care for Resident #4 on the 7:00am-3:00pm shift and

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3:00pm-11:00pm shift on 6/11/16 and again on 6/12/16. SN#2 stated that on 6/11/16 during the 3:00pm-11:00pm shift, she entered the resident's room to give his medications and found water and med pass (supplement) spilled over the resident's table and floor. She handed the resident his medications in a cup and went outside to get something to clean the spill. She revealed the resident was out of her sight for approximately twenty seconds. When she returned back into the resident's room, she did not see the medications or the cup. She stated when she asked the resident what he did with the medications, the resident replied he took the medications. But when she asked him what happened with the cup, the resident did not give her an answer. SN#2 revealed she attempted to search for those medications and the cup in the resident's room, but the resident became agitated and asked her to stop, and she complied with his request. SN#2 indicated the resident took all of his medications on 6/12/16 without incident.
SN#2 stated that on 6/13/16, Resident #4 was in the dining room when the Housekeeper Supervisor requested she come with him to the resident's room where she found ten packs of different medications in the drawer of the resident's nightstand. She revealed two pills were missing from the medication packs. SN#2 indicated she searched in the other drawers and his room to make sure there were not more medications hidden in the resident's room. The nurse stated she received in-services after the 6/13/16 incident regarding safe guarding medications. She revealed the in-service specifically instructed her when she received medications from the pharmacy, she should not lose sight of the medications until she placed them in the locked medication room or the

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medication cart. She also learned when she administered medication, she was required to make sure the resident swallowed the medication before she left the room.

During an interview on 6/17/16 at 5:00pm, the DCS stated no residents were without their medications during this time frame of two days. The DCS revealed the facility's nurses were trained (during orientation) to order residents' medications seven days before the medication card was empty, if the reorder date on the card allowed.

A review was conducted of the June 2016's MARs (medication administration records) for the ten residents whose medications were delivered and missing from 6/11/16-6/12/16. The MARs indicated the ten residents did not miss their scheduled medications.

The review of a typed interview by the SW (Social Worker) with Resident #4 on 6/13/16 revealed the resident found the medications up front by the nursing station and took the medications to his room. The resident indicated he ingested two doses of the medication in a green pack.

During an interview on 6/17/16 at 1:36pm, the facility's Medical Director stated Resident #4 was hyper-delusional, and had OCD (obsessive, compulsive disorder). The resident was extreme about taking medications; and was a severe hoarder.

During an interview on 6/18/16 at 2:30pm, DCS revealed as a result of the investigation of the incident, a Plan of Action was initiated on 6/13/16. The DCS stated on 6/13/16 she conducted an

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Inservice with facility nurses on medication delivery and never allowing medications out of their sight. Audits were completed using a ten day list faxed from the pharmacy and compared to the medications in the medication carts and in the medication storage room. A decision was made for the QA committee to review the audits monthly. Mock surveys were done daily (Monday-Friday) by department heads assigned to different areas of the facility and residents' rooms. The DCS revealed the resident did not have a roommate at the time of the incident (6/10/16-6/13/16).

The facility provided a plan of correction dated 6/13/16 with a correction date of 6/14/16. The plan of correction included:

On 6/13/16, the DCS (Director of Clinical Services) assessed the resident for harm or side effects from the incident. There was no evidence of harm or side effects. The DCS notified the Resident's physician of the incident and orders were received to monitor his vital signs, The family was also notified by the DCS. The DCS completed a medication variance report to document the incident.

On 6/13/16, the DCS requested a print out from the pharmacy of all pharmacy deliveries from the last 10 days. The DCS and Unit Manager audited the print out against the medications in the medication cart and the residents use of the medication to ensure all medications were accounted for and they were secured in the medication carts.

On 6/13/16, the DCS and Unit Managers re-educated all nursing staff on receiving

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medications from pharmacy and immediate securement of medications. The inservice instructed the nursing staff that when they receive medications from the pharmacy, they should not lose sight of those medications until they were secured in the medication cart or the medication room.

On 6/14/16, the DCS and Unit Managers conducted an audit of the pharmacy delivery records to ensure medications received were present on the medication cart. This will be conducted three times weekly for 12 weeks by the DCS and Unit Managers.

On 6/14/16, the DCS and Unit Managers randomly audited the receiving of medications from pharmacy and securement of medications by comparing the list of medications received with the medications in the medication cart or medication room. This audit will be conduced two times weekly for 12 weeks by the DCS and Unit Managers.

On 6/13/16 Mock surveys were done daily (Monday-Friday) by department heads assigned to different areas of the facility and residents ' rooms to look for hazards, environmental concerns, dirty laundry or any other concerns. These concerns were then given to the department heads for corrections/repairs to be made. At the end of each day during the meeting of department heads, each department head reported on resolutions made/completed.

Starting on 6/13/16, the audits will be reviewed monthly in QA&A meeting X 3 months. Any further action needed will be addressed. This will be completed by the Administrator.

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F 431	Continued From page 11 On 6/18/16 at 3:00pm evidence of the implementation of the correction action was conducted by review of audits: variance of delivered medication; observation of medication delivery; notebook showing/consisting of the Mock Surveys completed daily; inservice of all nurses on medication delivery from pharmacy and immediate securement of medications. Also, five staff nurses were interviewed about the inservice on the delivery and proper storage of medications. Observations revealed no issues/concerns.	F 431		