Riverside Convalescent Center – MATHEWS

P.O. BOX 370
Mathews, VA 23109

FACSIMILE COVER SHEET

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To : Elaine Cacciatore, LTC Supervisor	Date: April 14, 2016
Fax: 804 527 4502	Sender: Vickie Viers, RN
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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	PO BOX 370 MATHEWS, VA 23109

(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 000	INITIAL COMMENTS	F 000		

An unannounced Medicaid standard survey inspection was conducted 3/22/16 through 3/24/16. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Survey/Report will follow.

The census in this 60 certified bed facility was 60 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents #1 through #13 and #16 through #19) and 2 closed record reviews (Residents #14 through #15).

F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS — F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of nursing for two Residents (Residents' #10 and #11) in a survey sample of 19 Residents.

1. For Resident #10, medications were borrowed from another resident for use.
2. For Resident #11, the medication nurse gave the wrong medication.

The findings included:

Mary K. Skelton Jr. — Administrator — 4-14-2016
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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 281	Continued From page 1 Resident #10, was admitted to the facility 3/8/12. •Diagnoses included high blood pressure, diabetes, dementia and COPD (chronic obstructive pulmonary disease). Resident #1 O's most recent MDS (minimum data set) with an ARD (assessment reference date) of *3121/16* was coded as a quarterly assessment. The resident was coded as having severe cognitive impairment. Resident #10 was also coded as •extensive to total assistance of one to two staff members to perform activities of daily living (ADL's). On *3122116* at 4:05 PM, a medication pass observation was completed for Resident #10. LPN (licensed practical nurse) 8 was preparing Resident #1 O's Miralax, which she could not find in the medication cart. LPN (8) stated, "I will borrow from (name of Resident #12) and re-order." She then proceeded to obtain Resident #12's Miralax and poured the dose for Resident #10. On *3123116* at 3:35 PM, at the end of the day meeting, the ADON (assistant director of nursing) stated "No, we should not borrow medications." 2. For Resident #11 . the medication nurse gave the wrong medication. Resident #11 was adm itted to the facility on *616114.* Diagnoses included but were not limited to high blood pressure and depression. •Review of the resident's clinical record revealed •most recent MDS (minimum data set) with an ARD (assessment reference date) of *12120115.* The resident was coded as having a 81 MS (brief	F 281	F- 281 1- The medication was replaced for resident #10 April 6, 2016. Resident # 12 had medication replaced on April 6, 2016. Resident #11 continued to be monitored x 72 hours by nursing staff for any adverse impact having received the wrong medication. No adverse reactions were noted and the RP and MD were informed of the medication error 3/23/16. The nurses involved were counseled by the DON on 4/4/16. 2- All residents within the facility are at risk regarding failure to adhere to facility's policy and procedure on medication administration. 100% review of all residents medications to assure they were available for administration as ordered completed April 6, 2016. 3- A-The licensed nurses will receive re-education on 4/20/16 by clinical educator regarding the 6 rights of medication administration. B- Weekly medication administration observations will be performed 1 per week x 4 then monthly to ensure compliance with the medication policy and procedure. 4- The results of the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation by Administrator and/or DON 5- All corrective action will be completed by May 04, 2016	

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F 281	Continued From page 2 interview of mental status) of "3" out of a possible 15, or severe cognitive impairment. The resident was coded as requiring extensive to total assistance for ADLs (activities of daily living), such as bathing. On 3/23/16 at 8:15 AM, LPN (licensed practical nurse) A prepared Resident #11's medications. One liquid medications was poured; the dose was Lactulose (laxative) 30 cc (cubic centimeters) which was poured and administered to Resident#11. During the physician orders check of the clinical record, it was found that the resident did not have an order for Lactulose, but instead had an order, dated 12/31/15, for Prostat (a protein supplement) 30 cc twice daily. On 3/23/16 at 8:45 AM, LPN (A) was informed of the medication error. She stated, "I boo-booed. It was supposed to be Prostat, I was nervous." Review of the facility's Policy and Procedure regarding medication administration revealed the following: "Medications must be given accurately and appropriately for the resident to receive the intended therapeutic effect. Incorrect administration of certain drugs can result in harmful side effects." On 3/23/16 at 3:35 PM, the facility Administrator and DON (director of nursing) were notified of the above findings.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

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F 323	Continued From page 3 adequate supervision and assistance devices to prevent accidents.	F 323		

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation and clinical record review, the facility failed for one Resident (Resident #1) in a survey sample of 19 residents, and for one of two units, to provide a safe environment.

1. Resident #1 did not have wheelchair foot rests on the chair for transport.
2. LPN (licensed practical nurse) B left medications on top of the medication cart while out of sight of the medication cart.

The findings included:

Resident #1 was admitted to the facility on 5/1/14. Diagnoses included but were not limited to stroke with Alzheimer's dementia, high blood pressure and congestive heart failure.

Review of the resident's clinical record revealed most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/9/16. The resident was coded as having a BIMS (brief interview of mental status) of "2" out of a possible 15, or severe cognitive impairment. The resident was coded as requiring extensive to total assistance for ADLs (activities of daily living), such as locomotion on and off the unit.

Review of the clinical record revealed a nurses note, dated 11/12/15, with the following:

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F 323	Continued From page 4	F 323	F-323	

"Unable/unwilling to keep feet up while being pushed in the wheelchair, has to be reminded repeatedly to lift her feet, possible need for foot rests."

On *3/23/16* at 1 :25 PM, Resident #1 was observed while up in the wheelchair in the dining room. There were no foot rests on the wheelchair. She was not attempting to propel herself.

On 3/23/16 at 1 :35 PM, CNA (certified nursing assistant) A started to roll resident from the dining room and the resident put her foot down on the floor. CNA (A) was asked if the resident had foot rests for the wheelchair. CNA (A) stated, "None that I have used before." She went on to add that the resident had just started doing that. The CNA proceeded to propel the resident, stating "lift your feet." Resident #1 did lift her feet on command, but during the transport the resident was observed again to put both feet on the floor.

On 3/23/16 at 3:35 PM, the facility Administrator and DON (director of nursing) were notified of above findings.

On *3/24/16*, the DON presented a physician's order dated 3/23/16 for the following: "May use leg rests on wheelchair when needed to ensure safe transport when (Name of Resident #1) refuses to hold legs up."

On *3/24/16* at 9:55 AM, Resident #1 was observed with leg rests on the wheelchair.

2. LPN (licensed practical nurse) B left medications on top of the medication cart while

I-A – Order obtained for resident #1 and noted for use of leg rests on wheelchair when needed to ensure safe transport. Staff education regarding placement of leg rest routinely with removal when she indicates she is attempting to move self independently provided by DON, care planned and included in resident profile March 23, 2016.
B- Nurse B was counseled 1: 1 by DON regarding necessity to ensure medications and other items that could be ingested should not be left on top of the cart (Nurse A not present during this med pass).
C- C.N.A. (A) was re-educated to inform nursing staff of changes in condition using Stop & Watch form by DON March 23, 2016.
2- 2- An audit was performed on all residents completed on April 4, 2016 by DON to ensure every resident has proper assistive devices to prevent accidents.
3- A the licensed nurses will receive re-education by clinical educator on 4/20/16 regarding medication administration with focus on potential hazards and safety, education on leg rest use when pushing wheelchair(s).
B- The resident will be assessed for provision of assistance devices with any change in condition related to mobility weekly during our interdisciplinary AT Risk meeting by DON and/or designee beginning April 12, 2016.
C- An audit of all residents reviewed during AT Risk meeting weekly x4, then monthly x 3 by DON and/or designee to ensure provision of assistive devices to prevent accidents.
Audit of medication carts 1 weekly x4 weeks then 1 monthly by DON and/or designee to ensure medications and other items that could be ingested are not left on top of the medication cart.

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F 323	Continued From page 5	F 323	4- The results of the audits will be reported at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation by Administrator and/or DON. 5- All corrective action will be completed by May 04, 2016.	

out of sight of the medication cart.

Resident #10, was admitted to the facility *3/8/12*. Diagnoses included high blood pressure, diabetes, dementia and COPD (chronic obstructive pulmonary disease).

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of *3/2/16* was coded as a quarterly assessment. The resident was coded as having severe cognitive impairment.. Resident #10 was also coded as extensive to total assistance of one to two staff member to perform activities of daily living (ADL's).

On *3/22/16* at 4:05 PM, a medication pass observation was completed for Resident #10. LPN (licensed practical nurse) S was preparing Resident #10's Miralax, which she could not find in the medication cart. LPN (6) had poured and crushed the resident's Tylenol and placed into pudding, and had poured Lactulose (a laxative). LPN (A) left these on top of the medication cart to go across the hall into the closed clean utility room to look for another medication. While the door was closed and the medication cart was out of view, one resident propelled herself by the medication cart.

On *3/23/16* at 3:35 PM, the Administrator and DON (director of nursing) were notified of above findings.

On *3/24/16*, the DON presented the medication administration policy was presented and contained the following: "Medications and other items that could be ingested should not be left on top of the cart. Confused residents have been

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F 323	Continued From page 6 known to take them off the cart."	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, the facility staff failed, for 1 resident (Resident #4) in the survey sample of 19 residents, to administer oxygen per physician's order. The facility staff failed to ensure that Resident #4 received the correct amount of oxygen. The Findings included: Resident #4 was an 83 year old who was admitted to the facility on 6/20/14. Resident #4's diagnoses included Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, and Acute/Chronic Respiratory Failure.	F 328		

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F 328	Continued From page 7 The Minimum Data Set, which was a Annual Assessment with an Assessment Reference Date of 1/20/16 coded Resident #4 as usually being able to understand others, She was coded as being understood by others, In addition, Resident #4 was coded as having a Brief Interview of Mental Status Score of 15, indicating that she was cognitively intact. On 3/23/16 a review was conducted of Resident #4's clinical record, revealing a signed physicians order, dated 3/1116 that read, "Oxygen at 2 Liters per nasal cannula at all times." On 3/23/16 at 9:50 A,M, an observation was made of Resident #4 in her bed. Her oxygen concentrator flow rate was observed to be set at 1,5 liters per minute, On 3/23116 a review was conducted of facility documentation, revealing the Oxygen Concentrator Policy dated January, 2010 read, "Oxygen concentrators are another means of providing oxygen to our residents. The machines extract oxygen from room air and concentrate this oxygen for use by the resident. Safety precautions for concentrator. Turn flow meter to prescribed flow rate, Read flow rate at center of bali," On 3/23/16 at 2:45 P.M. a second observation was made of Resident #4 in her bed. Her oxygen concentrator was observed to be set at 1.5 liters per minute. On 3/23/16 at 2:45 an interview was conducted with LPN C. When asked what the oxygen level was set at, she stated, "It's below 2. Her order says 2, She needs every bit she can get She	F 328	F-328 1- A- Resident #4 had oxygen level corrected to setting as ordered by physician 3/23/16. All residents on oxygen were audited for appropriate settings on 3/23/16 by nursing supervisor. B- Immediate staff re-education was provided during shift huddle meetings 3/23/16 and 3/24/16 by DON to ensure immediate correction and to ensure all residents were receiving oxygen per physician's order. 2- All residents with physician ordered oxygen are at risk to not receive oxygen as ordered by physician. 3- A- the licensed nurses will receive re-education on 4/20/16 by clinical educator regarding necessity to comply with facility policy and procedure regarding oxygen administration, safety precautions for concentrator and correctly setting the flow rate as prescribed by the physician. B-All residents on oxygen will be audited 1xweek x 4 weeks, then one resident per week x 8 weeks, then 1 per month by Don and/or designee to ensure compliance with physician's order. 4- The results of the audits will be reported at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation by Administrator and/or DON. 5- All corrective action will be completed by May 04, 2016.	

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F 328	Continued From page 8 breathes through her mouth. She's not getting enough. The nurses are responsible for making sure that the oxygen is correct." LPN C then increased the setting to 2 liters per minute. On 3/23/16 at 4:00 P.M. the Director of Nursing (Administration B) and Administrator (Administration B) were made aware of the findings. No further information was received.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329\	Continued From page 9	F 329'		

This REQUIREMENT is not met as evidenced by:
- Based on staff interview, facility documentation
- review, clinical record review, the facility staff failed to ensure that one resident (Resident # 9) in the survey sample of 19 residents was free from unnecessary medication.

- For Resident # 9, the facility staff failed to obtain
- the pulse 78 times during February 2016 to March 2016 and failed to obtain blood pressure readings twice in March 2016 prior to
- administration of Metoprolol (a blood pressure medication) as per the physicians orders.

Findings included:

- Resident # 9, an 87 year old female, was admitted to the facility on *7/6/2010* with the diagnoses of, but not limited to, Vascular Dementia with Depression, Atrial Fibrillation, Coronary Artery Disease, Dysphagia, Osteoporosis Congestive Heart Failure, History of Cerebrovascular Attack (Posterior Parietal Stroke) and recent Pneumonia and Urinary Tract Infection.

- The most recent Minimum Data Set (MDS) was a
- quarterly assessment with an Assessment Reference Date (ARD) of *2/17/2016*. The MDS coded Resident # 9 with a BIMS (Brief Interview for Mental Status) of *4/15* indicating severe cognitive impairment; the resident was coded as in need of extensive help with two staff person assistance in activities of daily living; and
- frequently incontinent of bowel and bladder.

- Review of the clinical record was conducted on 3/23/2016. Review of the Physicians Orders

1-A- The provider and RP were informed 3/24/16 of the omission of the blood pressure and pulse monitoring for Resident #9 by the nursing supervisor. The resident was monitored each shift x 72 hours by nursing staff for any adverse reactions and none were noted.

2- All residents within the facility are at risk for omission of vital sign monitoring and adherence to the facilities medication policy and procedure.
3-A The licensed nurses will be re-educated by clinical educator regarding necessity to adhere to the facility policy and procedure regarding medication administration with focus on consistent assessments and documentation of all ordered parameters on 4/20/16
B- Audits will be performed by the DON and/or designee on all residents identified to receive medication with defined parameters weekly x 4 weeks then monthly x 3.
4 – The results of the audits will be reported at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the im0plementation by the Administrator and/or DON
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revealed an order dated 2/1/2016 for Metoprolol 25 mg (milligram) one tablet by mouth two times a day (930, 2100) (9:30 AM, 9:00 PM)-hold for heart rate less than 55, Systolic Blood Pressure less than 90."

Review of the February 2016 MAR (Medication Administration Record) revealed areas for the documentation of blood pressure and pulse rate prior to administration of Metoprolol at 9:30 AM and 9 PM. There was missing documentation of the pulse rate on several dates at 9:30 AM and 9 PM. The pulse was documented only 5 times out of 56 opportunities during the month of February 2016. The pulse was not documented 51 times in February 2016.

Review of the March 2016 MAR (Medication Administration Record) revealed missing documentation of pulse rate on several dates. The pulse was documented only 18 times out of 45 opportunities during the month of March 2016. The pulse rate was missing 27 times in March 2016.

Also, there was missing documentation of blood pressures on two dates 3/17/2016 at 9:30 AM and 3/20/2016 at 9:30 AM.

The pulse rate was not documented 51 times in February and 27 times in March equaling 78 times the pulse was not taken since the order was written on 2/1/2016.

Review of the Facility Policy on "Medication Administration" revealed on page 1 of 6 under C. Identify Residents:
"Medications should be charted during the med pass in a consistent manner before going to the

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	49E215	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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next resident."

On page 2 of 6 stated:
"E. Follow Your Facility Policy for Taking Vital Signs:
When medication administration is dependent on vital sign parameters, take them according to facility policy prior to pouring the medications."

F. Check Labeled Directions Against the "MAR" Prior to Giving Medication:
" Refer to the Medication Administration Record (MAR) to review drugs; verify medication strength, dose and labeled directions.
Never pass medications from memory.
Know your medications and their side effects."

On page 5 of 6 Under N. Medication Error Reporting and Monitoring:
"Medications must be given accurately and appropriately for the resident to receive the intended therapeutic effect.
Incorrect administration of certain drugs can result in harmful side effects."

Guidance for nursing practice for following physician's orders was included in Potter-Perry, Fundamentals of Nursing 7th Edition, page 336, "The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients."

"Metoprolol is in a group of drugs called beta-blockers. Beta-blockers affect the heart and circulation .You should not use this medication if

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you are allergic to Metoprolol, or if you have certain heart conditions such as slow heartbeats, or heart block."
http://www.drugs.com/metoprolol.html

An interview was conducted on 3/23/16 at 11:05 am, with Licensed Practical Nurse (LPN) D who reviewed the February 2016 MAR. When asked about the Metoprolol and the physician order to check the pulse prior to administration she stated, "the pulse should have been checked prior to giving the medication". LPN D provided copies of the February and March 2016 Medication Administration Record (MAR) and March 2016 signed Physicians Orders.

The Administrator, Director of Nursing, Assistant Director of Nursing and Corporate Nursing Consultant were informed of the findings at end of day briefing on 3/23/16 at 3:15 PM.

An interview was conducted on 3/23/16 at 3:30 PM, with the DON (Director of Nursing) regarding the Metoprolol administered without checking of the pulse rate. She stated, "The nurses are expected to take the pulse and document it before giving the medication." The DON also stated "the nurses took the blood pressures but did not take the pulse consistently." The DON also stated there was an "area on the MAR for the documentation of the pulse but they just did the blood pressure. They did not follow the doctor's orders."

The facility cited Mosby as the nursing standard reference source.

On 3/24/2016, the Director of Nursing presented a copy of "Resident Vital Sign Report" for

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F 329	Continued From page 13 2/1/2016 to 3/24/2016. The report showed additional dates that the pulse of Resident # 9 were taken as routine vital signs. The dates of the additional vital signs presented did not correspond with the dates and times of the missing documentation on the MAR prior to administration of Metoprolol. The Director of Nursing stated, "the nurses did not obtain the pulse prior to administering the medication as ordered by the doctor. They should have followed the doctor's orders." The Administrator, Director of Nursing, Assistant Director of Nursing and Corporate Nursing Consultant were informed of the findings at end of day briefing on 3/24/16 at 11:00 AM. No further information was provided.	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) 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. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425		

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F 425	Continued From page 14 services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed for one resident (Resident #10) in a survey sample of 19 residents, to ensure medications were available for use. Resident #10's Miralax was not available for use. The nurse then borrowed the medication from another resident. The findings included: Resident #10, was admitted to the facility 3/8/12. Diagnoses included high blood pressure, diabetes, dementia and COPD (chronic obstructive pulmonary disease). Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/2/16 was coded as a quarterly assessment. The resident was coded as having severe cognitive impairment. Resident #10 was also coded as extensive to total assistance of one to two staff members to perform activities of daily living (ADL's). On 3/22/16 at 4:05 PM, a medication pass observation was completed for Resident #10. LPN (licensed practical nurse) B was preparing Resident #10's Miralax, which she could not find in the medication cart. LPN (B) stated, "I will borrow from (name of Resident #12) and	F 425		

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re-order." She then proceeded to obtain Resident #12" Miralax and poured the dose for Resident #10.

On 3/23/16 at 3:35 PM, The Administrator and DON (director of nursing) were notified of above findings.

On 3/24/16 at 11 :05 AM, the ADON (assistant director of nursing) stated, "They are supposed to call the pharmacy and say we need it stat (right away). She went on to state that the medication could have been delivered that night.

1- The resident received the scheduled Miralax. Resident # 12 had medication replaced on April 6, 2016. Miralax was ordered 3/22/16 for resident #10. The provider and RP were notified of the occurrence 3/23/16 by nursing supervisor. LPN B was reeducated by the DON 3/23/16.

2- All residents within the facility are at risk regarding failure to ensure medications are available for use.

3- A- Mandatory staff re-education of all licensed nurses scheduled for April 20, 2016 regarding necessity to adhere to facility policy and procedure regarding medication administration with focus on ensuring medications are available for use and reordering procedure.
B- Will have 11p-7a nurse assess bulk medication supplies for all residents 3x week x 4 weeks, then weekly. She will reorder as indicated in order to ensure consistent supply of bulk medications. The results of these audits will be submitted to DON or designee in order to identify nurses who are not reordering medications timely.

4- The results of the audits will be reported at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation by the Administrator and/or DON

5- All corrective action will be completed by May 04,2016