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

PRINTED: 07/02/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495320	A. BUILDING ______ B. WING ______	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

(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 An unannounced Medicare/Medicaid standard survey 6/18/19 through 6/20/19. Corrections are required for compliance with the following Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 100 certified bed facility was 99 at the time of the survey. The survey sample consisted of 25 current Resident reviews and 3 closed record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to assess 1 of 28 Residents in the survey sample for safe self-administration of medication, Resident # 45. The findings included: The facility staff failed to assess Resident # 45 for safe self-administration of medication. Resident # 45 was an 89-year-old-female who was admitted to the facility on 6/9/15, with a readmission date of 1/9/19. Diagnoses included but were not limited to, anxiety, anemia, hypertension, and type 2 diabetes mellitus. The clinical record for Resident # 45 was	F 554	**F554** **Correction Action(s):** The nasal spray was removed from the resident's room on 6/19/19 and placed back on the medication cart. Resident #45 has been assessed using the Folstein Mini Mental Exam by the DON to determine if the resident is able to self-administer medication. It was determined that the resident is not able to self-administer his medications. A Facility Incident & Accident form was completed for this incident.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna W. Kennedy
TITLE: LNHA
(X6) DATE: 7/12/19

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 554	Continued From page 1 reviewed on 6/18/19 at 4:23 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/16/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 45 had a BIMS (brief interview for mental status) score of 4 out of 15, which indicated that Resident # 45's cognitive status was severely impaired. Resident # 45 had orders that included but were not limited to, "Ocean 0.65% nasal spray inhale 1 spray to each nostril BID (2 times daily) prn (as needed)," which was initiated by the physician on 1/9/19. On 6/9/19 at 10:38 am, the surveyor observed a bottle of nasal saline spray in a basket on Resident # 45's over bed table. On 6/9/19 at 11:05 am, the surveyor reviewed Resident # 45's clinical record and did not locate an assessment that determined that Resident # 45 was safe to self-administer medications. On 6/19/19 at 1:58 pm, the surveyor interviewed Resident # 45. The surveyor asked Resident #45 if she used the nasal spray that had been observed on her over bed table. Resident # 45 stated "Yes, but I don't use it no more than I have to." On 6/19/19 at 2:28 pm, the surveyor interviewed LPN # 1 (licensed practical nurse). The surveyor asked LPN # 1 if Resident # 45 had been assessed to self-administer medications. LPN # 1 stated that she was unsure but would look into it.	F 554	**Identification of Deficient Practice(s) and Corrective Action(s):** A 100% review of all resident rooms and bedside tables will be completed to check for medications that are being self-administered without assessment or a physician order by the DON, Unit Managers and/or designee. Any resident found to be self-administering medications without a physician order and an appropriate Folstein Mini-Mental Exam to determine their ability to safely and effectively self-administer medications will be corrected at time of discovery. The attending physician will be notified and a Folstein Mini-Mental Exam will be completed to determine if it is clinically appropriate for the resident to self-administer medications. A facility Incident & Accident form will be completed for all negative findings. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. All licensed staff and the interdisciplinary team will be inserviced by the DON and/or regional nurse consultant on the policy and procedure for self administration of medications, assessment used for determining self-administration of medications, as well as documenting in the residents comprehensive care plan and the need to obtain a physicians order for self administration of medication.	

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F 554

Continued From page 2

The facility policy on "Self-Administration of Medications" contained documentation that included but was not limited to,
..."Policy Interpretation and Implementation
1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident." ...

On 6/19/19 at 5:30 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 6/20/19.

F 554 — Plan of Correction

Monitoring:
The DON is responsible for compliance. The DON, Unit Managers, and/or charge nurse will review all documentation and communication daily for residents self administering medications to ensure medication was taken appropriately. All discrepancies found in these audits will be corrected at time of discovery and reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date:08/04/19

F 583 SS=D

Personal Privacy/Confidentiality of Records
CFR(s): 483.10(h)(1)-(3)(i)(ii)

§483.10(h) Privacy and Confidentiality.
The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,

F 583 — Plan of Correction

F583
Corrective Action:
Resident #18's privacy curtain between her and her roommate was pulled upon surveyor notification of the issue on 6/19/19.
A facility Incident & Accident form was completed for this incident.

Identification of Deficient Practice(s) & Corrective Action(s):
All residents may have been potentially affected. A 100% observation audit of all residents will be completed to ensure privacy was being provided for all residents. Any residents identified as being exposed during the audit will be corrected at time of discovery and staff involved will receive immediate inservice training. An Incident & Accident Form will be completed for any/all incidents of exposure

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F 583	Continued From page 3 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, and facility document review, the facility staff failed to ensure personal privacy for 1 of 28 Residents in the survey sample, Resident # 18. The findings included: The facility staff failed to ensure privacy for Resident # 18 while she disrobed in her room. Resident # 18 was a 71-year-old-female who was originally admitted to the facility on 9/30/14, with a readmission date of 6/29/18. Diagnoses included but were not limited to, anxiety, psychosis, auditory hallucinations, and hypertension. The clinical record for Resident # 18 was reviewed on 6/18/19 at 5:59 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/1/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 18	F 583	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All staff will be inserviced by the DON, and/or Social Services director on Resident Personal Privacy to include privacy for roommates. **Monitoring:** The DON is responsible for compliance. The DON, ADON and/or designee will perform two weekly rounds for resident privacy on each unit in order to maintain compliance. Any/all negative findings will be corrected immediately and disciplinary action will be taken as warranted. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 08/04/19**	

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F 583	Continued From page 4 had a BIMS (brief interview for mental status) score of 5 out of 15, which indicated that Resident # 18's cognitive status was severely impaired. The current plan of care for Resident # 18 was reviewed on 4/2/19. The facility staff documented a problem area for Resident # 18 as, "Mood/Behavior/Psychotropic drug use: Resident # 18 is noted to have a sad facial expression which usually is not altered with interaction she is noted to yell out and hit/kick at staff with care, education & risks have been explained little success d/t (due to) cognitive level. She is noted at times to take clothes off likes to be naked staff monitors for risk of exposing self she has dx (diagnosis) depression, anxiety, psychosis, agitation, ID (intellectual disability) schizophrenia, delusional d/o (disorder) hallucinations, no behaviors noted this review." Interventions included but were not limited to, "Explain procedures prior to giving care, approach in a calm manner, monitor facial/body lang (language) for likes/dislikes, if she becomes agitated allow time for her to calm down before cont (continuing)/giving care, provide calm environment, allow time for her to express herself." On 6/18/19 at 3:10 pm, the surveyor observed Resident # 18 sitting on the side of the bed during initial tour. The surveyor observed that the privacy curtain between Resident # 18 and her roommate had not been pulled. The surveyor observed that Resident # 18 had only a brief and her breast were exposed and visible to her roommate. On 6/18/19 at 5:49 pm, the surveyor observed Resident # 18 lying in bed wearing only a brief.	F 583		

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F 583	Continued From page 5 The surveyor observed that the privacy curtain between Resident # 18 and her roommate had not been pulled, and Resident # 18 was uncovered and her breast were visible to her roommate. On 6/18/19 at 5:57 pm, the surveyor interviewed Resident # 18's roommate Resident # 91.The surveyor asked Resident # 91 if Resident # 18 undressed often. Resident # 91 stated, "Yes, I see her get naked every day." The facility policy on "Resident Rights" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: t. privacy and confidentiality." ... On 5/19/19 at 5:30 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/20/19.	F 583		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health	F 645	F645 Corrective Action(s) Resident #52's attending physician and responsible party have been notified that the facility failed to obtain a level II PASRR for the resident prior to their admission. A facility Incident & Accident form has been completed for this incident.	

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F 645	Continued From page 6 authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,	F 645	**Identification of Deficient Practices & Corrective Action(s):** All other residents who were required to have a Level II PASRR prior to admission may have been affected. The social services director and/or Admissions director will complete a 100% review of all residents to identify residents who needed a level II PASRR completed prior to admissionbut did not have one. All negative findings will be corrected at the time of discovery by notifying the attending physician and responsible party. A facility Incident & Accident form has been completed for each incident. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time.The admission director, social worker, DON, and administrator have been inserviced by the regional nurse consultant on the requirement that residents with a mental disorder have a Level II PASRR be completed prior to admission **Monitoring:** The social worker and admissions director will be responsible for maintaining compliance.Potential new residents will be reviewed prior to their admission to ensure that a PASRR has been completed if indicated.Negative findings will be corrected at the time of discovery. Aggregate findings will be reported to the QA Committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date:08/04/19**	

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F 645	Continued From page 7 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that 1 of 28 Residents in the survey sample had a Level II PASARR, Resident # 52. The findings included The facility staff failed to ensure that Resident # 52 had a Level II PASARR (preadmission screening and resident review). Resident # 52 was a 74-year-old-female who was admitted to the facility on 3/6/18. Diagnoses included but were not limited to, schizoaffective disorder, depression, anxiety, and hypertension. The clinical record for Resident # 52 was reviewed on 6/18/19 at 3:38 pm. The most recent MDS (minimum data set) assessment was a	F 645		

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F 645	Continued From page 8 quarterly assessment with an ARD (assessment reference date) of 5/7/19. On 6/19/18 at 4:06 pm, the surveyor reviewed the "Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions" form for Resident # 52. The surveyor observed a handwritten checkmark documented next to "Refer for secondary assessment." On 6/19/19 at 4:21 pm, the surveyor interviewed the facility social worker and asked if Resident # 52 had a Level II PASARR. The facility social worker informed the surveyor that the documents that were provided were the only documents that the hospital had sent with Resident # 52 when she was admitted, but she would check to see if a Level II PASARR had been completed. On 6/20/19 at 9:24 am, the facility social worker informed the surveyor that Resident # 52 had not had a Level II PASARR assessment. On 6/20/19 at 10:15 am, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/20/19.	F 645		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684	**F684** **Corrective Action(s):** Resident #66's attending physician was notified that the facility staff failed to provide Restorative nursing services per physician order. A facility Incident & Accident form was completed for this incident.	

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F 684	Continued From page 9 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined the facility failed to provide physician ordered restorative services to 2 of 28 residents (Residents #66 and 89). Findings: 1. Facility staff failed to provide ohysician ordered restorative services for Resident # 66. His clinical record review was completed on 6/19/19 at 2:00 PM. Resident #66 was admitted to the facility on 7-9-17. His diagnoses included cerebral vascular accident, aphasia, and hemilpegia. The latest MDS (minimum data set) dated 5-17-19 coded the resident with unimpaired cognitive function. He required the assistance of nursing staff to accomplish all the ADLS (activities of daily living) with a set-up only to eat. The MDS captured one restorative session during the last 7 day look-back period. The latest CCP (comprehensive care plan) reviewed and revised on 5/20/19 addressed his need for staff assistance with ADLs. The interventions included "Restorative care as ordered". The resident's latest physician's orders were signed and dated on 521/19. These orders included "restorative care as ordered: AROM (Feed self every day); Transfers(Bed to chair	F 684	Residents #89's attending physicians was notified that the facility staff failed to provide Restorative nursing services per physician order. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered Restorative nursing services may have potentially been affected. The DON, ADON and/or Unit Manager will conduct a 100% audit of all residents with physician ordered Restorative nursing services to identify residents at risk. Residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and administering physician ordered medications, treatments and nursing services. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. To include following and providing Restorative nursing services per physician order.	

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F 684	Continued From page 10 every day); Ambulation (200ft every day with one assist); Dressing/Grooming (Brush hair every day)." The restorative care flow record for June 2019 was reviewed. Between Jun 1st and June 19th restorative was only documented as provided on five dates (6/5, 6/7, 6/19/ 6/12 and 6/14/19). The surveyor's findings were reported to the administrator and DON on 6/19/19 at 3:45 PM. On 6/20/19 at 8:26 AM the administrator told the surveyor that she agreed the restorative program needed some work. She presented the surveyor with a copy of the plan to restructure the program and ensure the residents got their physician ordered restorative care as planned. No additional information was provided prior to the survey team exit. 2. For Resident #89 the facility staff failed to follow physician's orders for performing restorative nursing services. Resident #89 was admitted to the facility on 07/14/17 and readmitted on 01/11/18. Diagnoses included but not limited anemia, hypertension, dementia, anxiety, depression, psychotic disorder, hypothyroidism and dysphagia. The most recent quarterly MDS (minimum data set) with and ARD (assessment reference date) of 05/23/19 coded the Resident as having both long and short term memory problems with significantly impaired cognitive skills for daily decision making. Resident #89's clinical record was reviewed on	F 684	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform weekly Restorative Nursing flow sheets audits to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 08/04/19**	

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	495320	A. BUILDING ______ B. WING ______	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

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F 684	Continued From page 11 06/19/19 and contained a signed physician's order summary for June 2019, which read in part "Restorative nursing for : PROM (passive range of motion) to left ad right UE/LE (upper extremity/lower extremity) x 5 reps qd (every day)". Resident #89's "Restorative Care Flow Sheet" for the month of June 2019 was reviewed on 06/19/19 and read in part, "PROM R and L UE/LE x 5 reps". The flow sheet was initialed for the PROM on 06/05/19, 06/07/19, 06/10/19, 06/12/19 and 06/14/19. There was no other documentation to indicate the PROM was being completed. The surveyor spoke with the RNC (regional nurse consultant) on 06/19/19 at approximately 1645. RNC stated that the flow sheets do not reflect what is actually being done. The concern of not following the physician's orders was discussed with the administrative team during a meeting on 06/19/19 at approximately 1615. No further information was provided prior to exit.	F 684		
F 742 SS=D	Treatment/Srvcs Mental/Psychosocial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the	F 742	F742 Corrective Action(s): Resident #91 has been seen by psych services per the attending physician recommendation. Resident #91 has also been reassessed by their attending physician and the resident's comprehensive plan of care has been revised accordingly. A facility Incident & Accident form has been completed for this incident	

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F 742	Continued From page 12 assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to ensure that 1 of 28 Residents in the survey sample received behavioral health services to attain the highest mental and psychosocial well-being, Resident # 91. The findings included The facility staff failed to provide information that consult psych services as ordered by the physician for Resident # 91 was completed. Resident # 91 was a 61-year-old-female who was originally admitted to the facility on 6/14/12, with a readmission date of 10/22/13. Diagnoses included but were not limited to, schizophrenia, unspecified intellectual disabilities, anxiety, and depression. The clinical record for resident # 91 was reviewed on 6/19/19 at 9:41 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/23/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 91 had a BIMS (brief interview for mental status) score of 6 out of 15, which indicated that Resident # 91's cognitive status was severely impaired. Resident # 91 had orders that included but were not limited to, "Refer to psych," which was initiated by the physician on 4/30/19. The current plan of care for Resident # 91 was	F 742	**Identification of Deficient Practice(s) & Corrective Action(s):** All other residents with recommendations for psych services consultation may have been affected.. The DON, ADON or Unit Managers will conduct 100% review of all residents for residents who have had psych services recommended, but have not been seen by psych. Residents identified at risk will be seen by psych services to establish appropriate treatment interventions. An incident & accident form will be completed for each incident. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON, Unit Managers and/or RCC will review the 24-hour report daily to insure that each resident's current medical needs including their psychosocial needs are being addressed in a timely manner to ensure that appropriate medical and psychological interventions are being obtained as ordered. All negative findings will be reported to administrator for immediate corrective action. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform chart audits weekly coinciding with the Care Plan calendar to monitor for compliance. Detailed findings of the audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:08/04/19**	

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F 742	Continued From page 13 reviewed and revised on 5/24/19. The facility staff documented a problem area for Resident # 91 as, "Mood/behavior/psychotropic drug use Resident # 91 has a dx (diagnosis) of anxiety/depression/schizophrenia. Resident # 91 has a flat effect on her face, which is altered with interactions. She is awake and alert with confusion noted at times. Usually understands she is noted to repeat phrases, then burst into laughter." Interventions included but were not limited to, "Meditele care as ordered." On 6/19/19 at 10:06 am, the surveyor reviewed the clinical record for Resident # 91 and did not locate any documentation that reflected that Resident # 91 had been seen by psych services. On 6/19/19 at 5:30 pm, the administrative team was made aware of the findings as stated above. On 6/20/19 at 8:36 am, the director of nursing informed thé surveyor that Resident # 91 had not been seen by psych services, but the facility would ensure that Resident # 91 was seen by psych services within the next couple of weeks. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/20/19.	F 742		
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	F 755	**F755** **Corrective Action(s):** Resident 21's attending physician has been notified that the facility failed to ensure that the physician ordered Namzaric was available from pharmacy for administration to Resident #21. A facility Incident and Accident form has been completed for this incident.	

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F 755	Continued From page 14 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 §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 staff interview and clinical record review, facility staff failed to ensure medications were available for administration to 5 of 28 residents in the survey sample (Residents #21, 197, 94, 75, and 16). 1. For Resident #21, Namzaric was unavailable for administration. Resident #21 was admitted to the facility on 10/12/18 with diagnoses including encephalopathy, heart failure, dementia,	F 755	Resident 197's attending physician has been notified that the facility failed to ensure that the physician ordered Marinol medication was available from pharmacy for administration. A facility Incident and Accident form has been completed for this incident. Resident 94's attending physician has been notified that the facility failed to ensure that the physician ordered Marinol was available from pharmacy for administration to Resident #94. A facility Incident and Accident form has been completed for this incident. Resident 16's attending physician has been notified that the facility failed to ensure that the physician ordered Cefdinir medication was available from pharmacy for administration to Resident #16. A facility Incident and Accident form has been completed for this incident. Resident 75's attending physician has been notified that the facility failed to ensure that the physician ordered Hydrocodone medication was available from pharmacy for administration to Resident #75. A facility Incident and Accident form has been completed for this incident.	

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F 755	Continued From page 15 pneumonia, dysphagia, hypertension, and major depression. On the quarterly minimum data set assessment with assessment reference date 4/10/19, the resident was assessed as having short and long term memory deficits and severely impaired cognitive skills and was assessed as without signs of delirium, psychosis, or behaviors affecting care. During clinical record review on 6/19/19, the surveyor noted the Medication Administration Record (MAR) was was marked "N" for Namzaric 28 milligram- 10 milligram capsule on 6/18/19. The MAR note for the entry did not provide an explanation. The nursing progress notes for 6/18/19 did not address the failure to administer the medication. There was no indication that the physician had been notified the medication had not been administered. The medication nurse stated the medication was not on the cart. The administrator and director of nursing were notified of the concern during a summary meeting on 6/19/19. 2. For Resident #197, Marinol was unavailable for administration. Resident #197 was admitted to the facility on 5/28/19 with diagnoses including chronic obstructive pulmonary disease, heart failure, pneumonia, dysphagia, hypertension, major depression, and chronic pain. The resident did not have a minimum data set assessment. The surveyor found the resident was not able to complete resident interview	F 755	**Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all resident's medication orders has been conducted by the DON, QA nurseand/ or Unit managersto identify residents at risk. Residents found to be at risk due the medications being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each. **Systemic Changes:** The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been inserviced on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy for administration. The inservice will include the steps the nurses should take should a medication not be delivered timely from the pharmacy. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON or Unit managerwill conductweekly audits of resident MAR's each week to confirm the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:08/04/19**	

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F 755	Continued From page 16 During clinical record review on 6/19/19, the surveyor noted the Medication Administration Record (MAR) was was marked "N" for Marinol 2.5 milligram capsule give 2 capsules by mouth two times per day on 6/12/19 through 6/18/19. The MAR notes were as follows: 1- Not administered- other on 6/13 8AM, 6/15 8AM, 6/15 4PM, 6/18 8AM, 6/18 4PM; 2- Not administered- other. Medication not delivered at this time. 'medication not available yet' on 6/13 4PM; 3- Not administered- Other pending order clarification on 6/14 at 8AM; 4-Other.special requirement not met 6/14 8PM; 5- held 'pending provider clarification', 6/16 8AM, 6/16 4PM, 6/17 8AM; 6- no explanation 6/17 4PM. The nursing progress notes for 6/13- 6/18/19 did not address the failure to administer the medication. There was no indication that the physician had been notified the medication had not been administered. During an interview on 6/20/19, the director of nursing reported that the medication had been ordered from the pharmacy and the paper prescription sent, but the pharmacy had not sent the medication. The administrator and director of nursing were notified of the concern during a summary meeting on 6/19/19. 3. For Resident #94, Marinol was unavailable for administration. Resident #94 was admitted to the facility on 5/31/19. Diagnoses included Alzheimer's, muscle weakness, dysphagia, hypertension,and gastroesophageal reflux disorder. On the	F 755		

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F 755	Continued From page 17 admission minimum data set assessment with assessment reference date 6/7/19, the resident scored 8/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. During clinical record review on 6/20/19, the surveyor noted the Medication Administration Record (MAR) was was marked "N" for Marinol 2.5milligram capsule give 2 capsules by mouth two times per day on 6/17/19 through 6/19/19. The MAR notes were as follows: 1- Not administered- other on 6/18 4PM and 6/19 8AM; 2- Not administered- other. 'pending' arrival from pharmacy' on 6/19 4PM; 3- Not administered- Other pending order clarification on 6/18 at 8AM. The nursing progress notes for 6/13- 6/18/19 did not address the failure to administer the medication. There was no indication that the physician had been notified the medication had not been administered During an interview on 6/20/19, the director of nursing reported that the medication had been ordered from the pharmacy and the paper prescription sent, but the pharmacy had not sent the medication. The administrator and director of nursing were notified of the concern on 6/20/19. 4. For Resident #16 the facility staff failed to ensure the medication Cefdinir was available for administration. According to "Davis Drug Guide", Cefdinir is an antibiotic used to treat bacterial infections. Resident #16 was admitted to the facility on	F 755		

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F 755	Continued From page 18 04/22/18 and readmitted on 05/18/19. Diagnoses included but not limited to anemia, hypertension, benign prostatic hyperplasia, diabetes mellitus, dementia, chronic obstructive pulmonary disease, intellectual disability, and dysphagia. The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 03/27/19 assigned the Resident a BIMS (brief interview for mental status) score of 6 out of 15 in section C, cognitive patterns. Resident #16's clinical record was reviewed on 06/19/19. It contained a signed physician's order summary for May 2019, which read in part "Cefdinir 250 mg/ 5 ml susp. Administer 6 ml vial g-tube BID (twice daily)". This order had a start date of 05/18/19. Resident #16's eMAR (electronic medication administration record) for the month of May 2019 was reviewed and contained an entry, which read in part "Cefdinir 250 mg/5 ml susp. Administer 6 ml vial g-tube BID". This entry was initialed with "N" on 06/19/19 at 9 AM, 06/20/19 at 9 AM and 5 PM. The notes section of the eMAR for these dates was reviewed and contained notes, which read in part "9:10 AM, 5/19/19 (Scheduled: 9:00 AM, 5/19/19; Cefdinir 250 mg/5 ml susp) Cefdinir 250 mg/5 ml susp Administer m...scheduled for 05/19/19 9:00 AM was not administered-other. pending provider clarification", "9:13 AM 5/20/19 (Scheduled: 9:00 AM, 5/19/19; Cefdinir 250 mg/5 ml susp) Cefdinir 250 mg/5 ml susp Administer m...scheduled for 05/19/19 9:00 AM was not administered-other. pending provider clarification", and "4:07 PM 5/20/19 (Scheduled: 9:00 AM, 5/19/19; Cefdinir 250 mg/5 ml susp) Cefdinir 250 mg/5 ml susp Administer m...scheduled for 05/19/19 9:00 AM was not	F 755		

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F 755	Continued From page 19 administered-other. pending provider clarification". The surveyor spoke with the DON (director of nursing) on 06/19/19 at approximately 1500 regarding Resident #16. DON stated that "N" on eMAR indicated the medication was not administered. She also stated that it was probably because the medication had not arrived from the pharmacy. The concern of the medication not being available for administration was discussed with the administrative team during a meeting on 06/19/19 at approximately 1615. No further information was provided prior to exit. 5. For Resident #75 the facility staff failed to ensure the medication hydrocodone was available for administration. Resident #75 was admitted to the facility on 02/10/19 and readmitted on 03/01/19. Diagnoses included but not limited to anemia, hypertension, pneumonia, anxiety, depression, chronic obstructive pulmonary disease, and benign prostatic hyperplasia. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/29/19 assigned the Resident a BIMS (brief interview for mental status) score of 12 out of 15 in section C, cognitive patterns. Resident #75's clinical record was reviewed on 06/19/19. It contained a signed physician's order summary for the month of May 2019, which read in part "Hydrocodone-acetamin 10-325 mg 1	F 755		

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F 755	Continued From page 20 tablet po (by mouth) three times a day". Resident #75's eMAR (electronic medication administration record) for the month of May 2019 was reviewed and contained an entry, which read in part "Hydrocodone-acetamin 10-325 mg 1 tablet po (by mouth) three times a day". This entry was initialed with "N" on 05/24/19 at 10:00 PM. The notes section of the eMAR contained a note, which read in part "10:47 PM, 5/24/19 (Scheduled: 10:00 PM, 5/24/19; Hydrocodone-acetamin 10-325 mg 1 tablet...scheduled for 05/24/2019 10:00 PM was not administered-Other.pending order clarification". The surveyor spoke with the DON (director of nursing) on 06/19/19 at approximately 1500 regarding Resident #16. DON stated that "N" on eMAR indicated the medication was not administered. She also stated that it was probably because the medication had not arrived from the pharmacy. The concern of the medication not being available for administration was discussed with the administrative team during a meeting on 06/19/19 at approximately 1615. No further information was provided prior to exit.	F 755		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		

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F 758	Continued From page 21	F 758		

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that—

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or

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Corrective Action(s):
Resident 45's attending physician was notified that facility staff failed to monitor resident #45for side effects and effectiveness of the physician ordered Lexapro. Resident 45's physician has reviewed resident 45'smedication regime and no adjustments to the medication regime are required. A facility Incident & Accident form was completed for this incident.

Resident 56's attending physician was notified that facility staff failed to monitor resident #56 for side effects and effectiveness of the physician ordered Trazadone. Resident 56's physician has reviewed resident 56's medication regime and no adjustments to the medication regime are required. A facility Incident & Accident form was completed for this incident.

Resident 65's attending physician was notified that facility staff failed to monitor resident #65 for side effects and effectiveness of the physician ordered Prozac. Resident 65's physician has reviewed resident 65's medication regime and no adjustments to the medication regime are required. A facility Incident & Accident form was completed for this incident.

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prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review the facility staff failed to ensure that 4 of 28 Residents in the survey sample were free of unnecessary psychotropic medications, Resident #45, Resident #56, Resident #65, and Resident #89.

The findings included

1. The facility staff failed to monitor Resident # 45 for side effects and effectiveness of Lexapro.

Resident # 45 was an 89-year-old-female who was admitted to the facility on 6/9/15, with a readmission date of 1/9/19. Diagnoses included but were not limited to, anxiety, major depressive disorder, hypertension, and type 2 diabetes mellitus.

The clinical record for Resident # 45 was reviewed on 6/18/19 at 4:23 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/16/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 45 had a BIMS (brief interview for mental status) score of 4 out of 15, which indicated that Resident # 45's cognitive status was severely impaired.

The current plan of care for Resident # 45 was reviewed and revised on 4/17/19. The facility staff documented a problem area for Resident # 45 as, "Mood & behavior, psychosocial wellbeing &

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Resident 89's attending physician was notified that facility staff failed to monitor resident #89 for behaviors related to the administration of the physician ordered Seroquel. Resident #89's physician has reviewed resident #89's medication regime and no adjustments to the medication regime are required. A facility Incident & Accident form was completed for this incident.

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents receiving psychotropic medications may have been potentially affected. The DON, ADON, and/or Pharmacy consultant will review the medication orders of all residentsreceiving psychotropic medication toidentify residents without appropriate psychotropic medication monitoring. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding.

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F 758	Continued From page 23 psychotropic drug use: Resident # 45 has a dx (diagnosis) of depression/anxiety, Resident # 45 is alert & oriented, she smiles and says she enjoys bingo, Resident # 45 does say she gets anxious. For this review Resident # 45 has not exhibited any behaviors. GDR (gradual dose reduction) done this review, please see chart." Interventions included but were not limited to, "Notify MD (medical doctor) of any changes." Resident # 45 had current orders that included but were not limited to, "Escitalopram (Lexapro) 20 mg (milligram) tablet one po (by mouth) QD (every day) dx depression," which was initiated by the physician on 1/9/19. On 6/19/19 at 1:41 pm, the surveyor reviewed the June 2019 medication administration record for Resident # 45. The surveyor did not locate any documentation that reflected that the facility staff had monitored Resident # 45 for side effects and effectiveness associated with the use of Lexapro. The surveyor also reviewed the facility "Psychotropic Medication Quarterly Eval" form for Resident # 45 that had been completed by facility staff on 4/16/19. The surveyor did not locate any documentation that the facility staff evaluated Resident # 45 for side effects and effectiveness associated with the use of Lexapro. On 6/19/19 at 5:30 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/20/19. 2. The facility staff failed to monitor Resident # 56 for side effects and effectiveness associated	F 758	**Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring for behaviors, side effects and effectiveness of psychotropic medications. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will complete weekly physician orders and MAR audits on all residents receiving psychotropic medications to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:08/04/19**	

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F 758	Continued From page 24 with the use of Trazodone. Resident # 56 was a 57-year-old-female who was originally admitted to the facility on 12/10/10, with a readmission date of 12/9/11. Diagnoses included but were not limited to, anxiety, major depressive disorder, anemia, and pain. The clinical record for Resident # 56 was reviewed on 6/18/19 at 4:37 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/9/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 56 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 56's was cognitively intact. The current plan of care for Resident # 56 was reviewed and revised on 5/10/19. The facility staff documented a problem area for Resident # 56 as, "Mood/behavior/psychotropic drug use: Resident # 56 has a dx (diagnosis) of psychosis, paranoid schizophrenia, anxiety, mental d/o (disorder) depression. Resident # 56 does exhibit behaviors such as yelling from door of room up hall to nursing staff instead of using CB (call bell) she exhibits with persistant thoughts of fantasy ie (for example) male vendors comes to the building she gravitates to them. She has germ phobia will ask staff not to put things in her trash can, doesn't like when roommates using the commode in room." Interventions included but were not limited to, "Notify MD (medical doctor)/ RP (responsible party) of any changes." Resident # 56 had orders that included but were not limited to, "Trazodone 150 mg (milligram)	F 758		

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F 758	Continued From page 25 tablet 1 po (by mouth) QHS (every night at bedtime)," which was initiated by the physician on 6/18/18. On 6/19/19 at 1:30 pm, the surveyor reviewed the June 2019 medication administration record for Resident # 56. The surveyor did not locate any documentation that reflected that the facility staff had monitored Resident # 56 for side effects and effectiveness associated with the use of Trazodone. The surveyor also reviewed the facility "Psychotropic Medication Quarterly Eval" form for Resident # 56 that had been completed by facility staff on 5/9/19. The surveyor did not locate any documentation that the facility staff evaluated Resident # 56 for side effects and effectiveness associated with the use of Trazodone. On 6/19/19 at 5:30 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/20/19. 3. The facility staff failed to monitor Resident # 65 for side effects and effectiveness associated with the use of Prozac. Resident # 65 was an 86-year-old-female who was admitted to the facility on 2/28/19. Diagnoses included but were not limited to, hypertension, depression, and type 2 diabetes mellitus. The clinical record for Resident # 65 was reviewed on 6/18/19 at 4:13 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment	F 758		

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F 758	Continued From page 26	F 758		

reference date) of 5/8/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 65's cognitive status was moderately impaired.

The current plan of care for Resident # 65 was reviewed and revised on 5/9/19. The facility staff documented a problem area for Resident # 65 as, "Mood/behavior/psychotropic drug use: psychosocial wellbeing Resident # 65 has a dx (diagnosis) of dementia, depression and mild cognitive impairment. Resident # 65 denies feeling depressed however sometimes has looks of sadness but will communicate with staff. Answers questions and is cooperative." Interventions included but were not limited to, "Notify MD (medical doctor) of any changes."

Resident #65 had orders that included but were not limited to, "Fluoxetine HCL (Prozac) 10 mg (milligram) capsule give one by mouth every morning for depression," which was initiated by the physician on 2/28/19.

On 6/19/19 at 1:10 pm, the surveyor reviewed the June 2019 medication administration record for Resident # 65. The surveyor did not locate any documentation that reflected that the facility staff had monitored Resident # 65 for side effects and effectiveness associated with the use of Prozac. The surveyor also reviewed the facility "Psychotropic Medication Quarterly Eval" form for Resident # 65 that had been completed by facility staff on 5/7/19. The surveyor did not locate any documentation that the facility staff evaluated Resident # 65 for side effects and effectiveness associated with the use of Prozac.

On 6/19/19 at 5:30 pm, the administrative team

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F 758	Continued From page 27	F 758		

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was made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 6/20/19.
4. For Resident #89 the facility failed to monitor behaviors related to the administration of the psychotropic medication Seroquel.

Resident #89 was admitted to the facility on 07/14/17 and readmitted on 01/11/18. Diagnoses included but not limited anemia, hypertension, dementia, anxiety, depression, psychotic disorder, hypothyroidism and dysphagia.

The most recent quarterly MDS (minimum data set) with and ARD (assessment reference date) of 05/23/19 coded the Resident as having both long and short term memory problems with significantly impaired cognitive skills for daily decision making.

Resident #89's clinical record was reviewed on 06/19/19. It contained a signed physician's order summary for June 2019, which read in part "Seroquel (quetiapine) 25 mg tablet take 1 pill po (by mouth) qd (every day)". Resident #89's eMAR (electronic medication administration record) for June 2019 was reviewed and contained an entry, which read in part "Seroquel (quetiapine) 25 mg tablet take 1 pill po (by mouth) qd (every day)". The eMAR indicated the Resident is receiving the medication as prescribed.

Resident #89's clinical record contained "Psychotropic Medication Quarterly Evaluation" forms dated 09/12/18, 12/05/18 and 05/22/19. The evaluation section of the form was incomplete for all forms and the behavior

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F 758	Continued From page 28 warranting use of medication section and the episode/week section was incomplete on the form dated 05/22/19. The concern of the incomplete Psychotropic Medication Evaluation forms was discussed with the administrative team during meeting on 06/19/19 at approximately 1615. No further information was provided prior to exit.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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.	F 761	**F761** **Corrective Action(s):** The expired vial of Lorazepamfound in the Medication room was removed and destroyed. A Facility Incident & Accident form has been completed for thisincident. The left side medication cart found to have loose pills in two of the medication drawers has been reviewed and all loose medications have been removed and disposed of. A Facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All unit medication rooms,medication refrigerators and medication carts used for the storage medications may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of the medication room, medication carts, and medication refrigerators to identify any expired or loose medications. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident Form will be completed for each incident identified.	

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F 761	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to store drugs in accordance with accepted professional principles and to discard expired medications in one medication room and on one medication cart. On 6/19/19 at 1:40 PM, during medication storage room examination, in the right side medication storage refrigerator, the surveyor found a vial of lorazepam 20 milligram/10 milliliter labeled for un-sampled Resident #37 which had expired 9/2018. Record review revealed the resident did not have a current order for lorazepam by injection. Inspection of the left side back hall medication cart revealed more than 10 loose pills in each of two of the medication storage drawers. The medication nurse disposed of the medications. The administrator and director of nursing were notified of the concern during a summary meeting on 6/19/19.	F 761	**Systemic Change(s):** Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the facility policy and procedure for storing medications and biologicals. The nursing staff will also be inserviced on the Medication Administration Policy and Procedure to include weekly review of all Medication rooms, medication refrigerators and medication carts for medications to include injectables and unrefrigerated medications and biologicals that may be expired or opened with no date or laying loose in in the medication carts. In addition, The Pharmacy consultant will check each medication room and each medication cart for improper storage of medications during scheduled visits **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or unit manager will perform weekly Medication room and Medication cartaudits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 08/04/19**	

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