STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345128	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

(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 The Division of Health Service Regulation (DHSR) conducted an onsite follow up and complaint investigation dated 06/08/16. The facility was in compliance with the Federal regulations. A reinvestigation of NC00117447 was conducted on 09/29/16 and deficient practice at harm level was identified in 483.25 on 05/19/16 through 06/06/16. A complaint investigation was conducted on 09/29/16 and the facility remains out of compliance. Survey event ID# S03911.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157		10/24/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/24/2016

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F 157	Continued From page 1 regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and physician and staff interviews the facility failed to follow a physician order that stated to notify the physician of a blood sugar that was over 400 for 1 of 1 residents sampled for notification (Resident #2). The findings included: Resident #2 was initially admitted to the facility on 07/08/16 and most recently readmitted to the facility on 09/16/16 with diagnoses that included diabetes mellitus. Review of the most recent comprehensive Minimum Data Set (MDS) dated 07/18/16 revealed that Resident #2 was cognitively intact and required extensive assistance of 2 staff members for bed mobility, transfers, and toilet use. The MDS also revealed that Resident #2 received 7 days of insulin injections during the review period. Review of a physician order dated 07/08/16 read finger stick blood sugar before meals and at bedtime for insulin dependent diabetes mellitus. Review of a physician order dated 08/25/16 read Novolog Flexpen inject per sliding scale: if blood sugar is 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, if blood sugar is greater than 400 give 8 units and call Medical	F 157	F157 1. Dr was notified that Resident #2's blood sugar was over 500 by Unit Manager on 10/23/16 after agency nurse failed to document notifying the doctor earlier. Dr. in agreement with staff how staff handled high blood sugar for the resident and instructed to change MD call to same as Med Director 2. All residents receiving finger stick blood sugar monitoring have the potential to be affected by this alleged deficient practice. The Nurse Managers conducted an audit of all residents receiving finger stick blood sugar monitoring to ensure the physician was notified when blood sugar values are outside of the ordered range. This audit was completed on 10/21/16. 3. Licensed Nurses was re-educated by Corporate Nurse and Facility Nursing Management regarding the facility's policy for Physician Notification. This re-education was completed by 10/7/16. The Nurse Managers will review 5 residents receiving finger stick blood sugar monitoring weekly to 12 weeks to ensure the physician is notified of blood sugar values outside of the ordered range. Opportunities will be corrected as	

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F 157	Continued From page 2 Doctor (MD) subcutaneously before meals and at bedtime for diabetes mellitus. Review of the Medication Administration Record (MAR) dated 09/01/16 through 09/30/16 revealed that on 09/04/16 at 4:30 PM Resident #2's blood sugar was 536 and 8 units of Novolog was administered subcutaneously. Review of Resident #2's medical record revealed no physician notification was made on 09/04/16 at 4:30 PM when Resident #2's blood sugar was 536. Interview with Resident #2 on 09/28/16 at 12:20 PM revealed that the staff checked her blood sugar 4 times a day but could not remember if they had ever told her that it was over 400. Interview with Certified Medication Aide (CMA) #1 on 09/28/16 at 3:24 PM revealed that he was working with Resident #2 on 09/04/16 but was unable to recall which nurse was working with him. CMA #1 stated that he did not remember the exact evening or occurrence but stated that he would have checked Resident #2's blood sugar and the nurse would have administered the insulin. CMA#1 stated that if Resident #2' s blood sugar would have been 536 he would have immediately told the nurse and the nurse would have contacted the doctor and documented in the medical record. Interview with Nurse #10 on 09/28/16 at 4:24 PM revealed that she was an agency nurse and had only worked at the facility 2 days. Nurse #10 did not recall Resident #2 or the occasion when Resident #2's blood sugar was 536.	F 157	identified. 4. The DON will report the results of this monitoring to the QAPI committee monthly for 3 months and the committee will make recommendations as needed.	

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F 157	Continued From page 3 Interview with the Director of Nursing (DON) on 09/29/16 at 4:33 PM revealed that each resident had individualized diabetic orders. The DON stated if the resident's blood sugar was over 400 and the resident's order stated to call the physician then the nurse should have contacted the physician and completed a Situation, Background, Assessment, and Recommendation (SBAR) in the medical record. The DON reviewed Resident #2's medical record and stated that no notification to the physician was documented and she would assume that it was not done. The DON stated she expected the staff to follow physician orders and if the order stated to contact the physician for blood sugar over 400 then the physician should have been notified. Interview with Physician #1 on 09/29/16 at 4:56 PM revealed that he could not say for sure that he was notified of Resident #2's blood sugar of 536 on 09/04/16. Physician #1 stated that he would expect the staff to contact him if a resident's blood sugar was greater than 400, "they have my cell phone number and they can always call me."	F 157		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by:	F 223		10/24/16

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F 223	Continued From page 4 Based on observation, record reviews, resident interview and staff interviews, the facility failed to protect resident from misappropriation/diversion of their controlled medications for 1 of 3 sample residents (Resident #16). The findings included: Resident #16 was admitted to the facility on 08/10/2016. Her diagnoses included high blood pressure, Diabetes Mellitus, hemiplegia, and chronic pain. The most recent Minimum Data Set dated 09/11/2016 coded Resident #16 as cognitively intact, having clear speech with adequate vision and hearing. A review of Resident #16's care plan dated 08/21/2016 revealed that she had pains related to the fracture of left pubic and sacrum resulted from a fall prior to her admission to the facility. The goal of the pain therapy was for Resident #16 to have adequate relief of pain. Interventions included anticipated Resident #16's needs for pain relief and responded immediately to complaint of pain. Review of Pharmacy packing slips and facility's receipts for controlled drugs revealed that the following shipments of Oxycodone with Acetaminophen (Percocet) 5/325 milligrams (mg) for Resident #16 had been delivered by the pharmacy and received/signed by the facility staff: · 08/10/2016; Quantity = 60 tablets; Shipping number - 519224 · 09/20/2016; Quantity = 30 tablets; Shipping number - 528002 The facility had received a total of 90 tablets of Percocet 5/325 mg for Resident #16 since her	F 223	F223 1. The Director of Nursing immediately obtained replacement medications for resident #16 on 9/29/16 to ensure the resident received medications as needed and ordered. The Nurses involved were immediately suspended on 9/28/16 by the Director of Nursing A 24 hour report was initiated on 9/29/16 by the DON and Administrator and an investigation was completed. On 9/29/16 the DON and Administrator completed a 5 day report regarding diversion of controlled substances and outlined the details of the investigation. The Nurses involved were terminated by the DON on 9/29/16. 2. All residents receiving controlled substance have the potential of being affected by this alleged deficient practice. The Director of Nursing and Nurse Managers conducted an audit of current narcotic sign out logs for current residents receiving controlled substances to validate an accurate count of these medications. No other discrepancies were identified. This audit was completed on 9/30/16. 3. All staff were re-educated on the facility policy for Abuse Prohibition by the Corporate Nurse and the Facility Nursing Management. This re-education will be completed by 10/7/16. Licensed Nurses will be re-educated on the facility's policy for monitoring and securing controlled substances. Going forward, Controlled Substances will be counted and the sign out logs will also be counted at each change of shift. The Controlled Substance count accuracy will be validated by the floor nurse at change of	

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F 223	Continued From page 5 admission on 08/10/2016. Review of physician's order dated 08/10/2016 revealed that Resident #16 was prescribed with the following two pain medications: · Percocet 5/325 mg, one tablet by mouth every six hours as needed for pain, · Gabapentin 100 mg, one capsule by mouth three times daily for pain. Review of Resident #16's electronic Medication Administration Records (eMAR) revealed that she had taken 3 tablets of Percocet 5/325 mg in August, 2016; and 10 tablets in September by 09/29/2016. Each tablet of Percocet administered by the nurse was charted in the eMAR with nurses' initial, date and time of administration, and its effectiveness. Review of the facility staff roster for 100 Hall revealed that Nurse #4 was working on 09/27/2016 from 3 to 11 PM. Nurse #5 who took over the shift on 09/27/2016 was working from 11 PM to 7 AM. The next shift was covered by Nurse #6 on 09/28/2016 from 7 AM to 3 PM. Then, the shift was transitioned to Nurse #4 again on 09/28/2016 at 3 PM. In a phone interview conducted on 09/29/2016 at 11:20 AM, Nurse #4 stated that she assumed the shift from Nurse #6 at 3:00 PM on 09/28/2016. During the shift transition, she matched all the Declining Inventory Count Sheet (DICS) for each card of controlled drugs in the top locked compartment and counted the total number of controlled drug cards in the bottom locked compartment. She found no discrepancies according to the balance shown on bottom locked compartment Controlled Drugs-count Record	F 223	shift daily and the Nursing Management will reconcile this paperwork weekly for compliance with new system. The Director of Nursing and Nurse Managers will randomly audit the controlled substance monitoring sheets for 10 residents weekly for 12 weeks to validate accurate storage and monitoring. Opportunities will be corrected as identified. 4. The DON will report the results of this monitoring to the QAPI committee monthly for 12 months and the committee will make recommendations as needed.	

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(CDR). When Resident #16 requested the Percocet on 09/28/16 around 3:45 PM, Nurse #4 found that the whole card of Percocet 5/325 mg was missing. Nurse #4 recalled she had given Resident #16 Percocet 5/325 mg a day before and it should have at least 26 pills remained in the card. According to Nurse #4, Resident #16's Percocet were in the medication cart when she transitioned the shift to Nurse # 5. She alerted Nurse #8 who was the Unit Manager to help searching for the missing controlled drugs but they were unable to find the missing Percocet. Nurse #4 had to retrieve the Percocet 5/325 mg later from the Pixel.

In a phone interview conducted on 09/29/2016 at 12:49 PM, Nurse #7 stated that she could not recall any specific incident occurred on 09/06/2016.

In a phone interview attempted on 09/29/2016 at 1:03 PM, Nurse #6 did not answer or return the call.

In an interview conducted on 09/29/2016 at 1:08 PM, Resident #16 stated that she had history of pain at her left lower extremity. She needed approximately 2 tablets of Percocet per week and it had been effective for her pain relief. She had one tablet of Percocet on 09/27/2016 around 8:30 PM and the next tablet on 09/28/2016 around 4:30 PM. She remembered both pain pills were administered by the same nurse.

On 09/29/2016 at 1:08 PM, Resident #16 was observed having no signs or symptoms of pain or discomfort.

In an interview conducted on 09/29/2016 at 1:20

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PM, Nurse #8 stated that the incident of missing Percocet 5/325 mg was reported to her by Nurse #4 on 09/28/2016 around 4:15 PM. Nurse #4 told her that she had given Resident #16 one tablet of Percocet 5/325 mg the night before and at least 26 pills should be remained in the top locked compartment. During the investigation, Nurse #8 found that the DICS for Resident #16's Percocet 5/325 mg was also missing. With the assistance of the consultant pharmacist, Nurse #8 confirmed that Resident #16 had used 13 tablets of Percocet 5/325 mg since her admission on 08/10/2016. 1 of the 13 tablets was retrieved from the Pixis. The pharmacy had delivered a total of 90 tablets Percocet 5/325 mg for Resident #16 so far. A total of 78 tablets of Percocet 5/325 mg for Resident #16 were missing. Once Nurse #8 confirmed the missing of Percocet, she reported the incident to the Director of Nursing (DON) around 5:00 PM on 09/28/2016.

In an interview conducted on 09/29/2016 at 3:40 PM, the consultant pharmacist stated when she realized that the DICS for Resident #16's Percocet 5/325 mg and the medication were both missing, she suspected it was a deliberate action to embezzle the controlled drugs from the facility.

In a phone interview conducted on 9/30/2016 at 4:16 PM, Nurse #5 stated that during the shift change on 09/27/2016 at 7:00 AM, she matched each controlled drug cards with its DICS for the top locked compartment and counted the total number of controlled drug cards for the bottom locked compartment. She found no discrepancies for both locked compartments.

In an interview conducted on 09/29/2016 on 3:20 PM, the DON stated that all controlled drugs in

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F 223	Continued From page 8 the top locked compartment must have a DICS with matching prescription numbers. It was her expectation for all the nurses to fill out the DICS each time when they dispensed controlled drugs and to verify, track, and document the balance of controlled drug cards in the CDRs for both locked compartments during shift transition. Once the nurse signed the CDRs during shift transition, he/she would be accountable for the controlled drugs until the medication cart signed over to another nurse.	F 223		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to have a visually impaired residents personal items such as a bowl placed within the resident's reach for a resident for 1 of 1 sampled resident (Resident #2). The findings included: Resident #2 was initially admitted to the facility on 07/08/16 and most recently readmitted to the facility on 09/16/16 with diagnoses that included diabetes mellitus, dementia, hemiplegia, and	F 246	F246 1. Resident #2's red bowl was verified within reach by the unit manager on 9/30/16 2. Residents with visual impairments have the potential to be affected by this alleged deficient practice. An audit of all residents to identify those with visual impairments was conducted by the Nurse Managers on 10/4/16 and care plans for these residents were updated to include individual needs and preferences required to assist with managing these visual	10/24/16

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F 246	Continued From page 9 hypertension. Review of the most recent comprehensive Minimum Data Set (MDS) dated 07/18/16 revealed that Resident #2 was cognitively intact and vision was adequate. The MDS also revealed that Resident #2 required extensive assistance of 2 staff members for bed mobility, transfers, and toilet use. Observation and interview with Resident #2 on 09/28/16 at 12:20 PM revealed Resident #2 up in wheelchair with her sunglasses on in her room and was visibly upset. When I asked Resident #2 what was wrong she replied "I am blind to a point and every time I leave my room they move my things around on my table, and I can't find my bowl that I keep all my personal stuff in." The bowl was sitting in a chair at the foot of Resident #2's bed, I point it out to Resident #2 and she stated "yes that is my red bowl that I have been looking for" after getting 3 to 4 inches from the bowl and inspecting the bowl to make sure that was what she was looking for. Resident #2 stated "I looked for it but with my vision I could not see it." Resident #2 stated that they move my bowl a lot and I tell them all the time to please leave it on my table so I can find my things, I keep all my personal stuff in there. Resident #2 reached into the bowl and pulled out a small phone book and stated she was going to call her family. When I asked Resident #2 if she could read the phone book she replied "no I can't see the numbers the staff has to look up the number and dial it for me." Resident #2 stated that she had a stroke years ago and it took most of her eye sight but she was able to see the colors red, black, and dark green the best. Resident #2 stated I recognize the staff by the sound of their voices. Observation on 09/29/16 at 9:29 AM Resident #2	F 246	impairments. CNA assignment sheets will include individual needs and preferences for the visually impaired. 3. Nursing Staff was re-educated by Corporate Nurse and Facility Nursing Management on following the care plan for individual needs and preferences for those resident with visual impairments. This re-education was completed on 10/7/16. The Director of Nursing and Nurse Managers will randomly observe 5 residents with identified visual impairments weekly for 12 weeks to ensure the care plan for individual needs and preferences is followed. Opportunities will be corrected as identified. 4. The DON will report the results of this monitoring to the QAPI committee monthly for 3 months and the committee will make recommendations as needed.	

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was in bed with eyes closed, her breakfast tray was on her bedside table and her red bowl was across the room out of Resident #2's reach.

Interview with Nurse Assistant (NA) #3 on 09/28/16 at 3:00 PM revealed that took care of Resident #2 on first shift and that she was unaware of Resident #2's visual impairment and the importance of Resident #2's red bowl or the contents of the bowl. NA #3 stated that she had not moved the bowl off of her bedside table and did not know who had moved it.

Observation and interview with Resident #2 on 09/29/16 at 12:08 PM Resident #2 was in her wheelchair with her sunglasses on she was again visibly upset that her red bowl had been moved across the room to the TV stand and was not on her bedside table. Resident #2 stated "I tell them and I tell them but they don't listen to me."

Interview with NA#2 on 09/29/16 at 1:24 PM revealed that she was taking care of Resident #2 and she was not aware if Resident #2 had a visual impairment or not she would have to ask the nurse. NA #2 stated that she had delivered Resident #2 her breakfast tray and had moved her red bowl to the TV stand because her bedside table was cluttered and there was "nowhere else to put it." NA #2 stated that Resident #2 was very particular about her things but she was unaware of the importance of the red bowl or its contents.

Interview with Director of Nursing (DON) on 09/29/16 at 2:19 PM revealed that Resident #2 often changed her story and the things that were important to her may change from day to day. The DON stated that they needed to have

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F 246	Continued From page 11 conversation with Resident #2 about what persona items she would like to be within her reach and then she would expect the staff to make sure those items are within her reach at all times. The DON stated she was unaware of Resident #2's visual impairment or the importance of her red bowl and its contents.	F 246		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		10/24/16

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F 278	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to assess a resident's vision accurately on the Minimum Data Set (MDS) for 1 of 1 sampled resident reviewed with a visual impairment (Resident #2). The findings included: Resident #2 was initially admitted to the facility on 07/08/16 and most recently readmitted to the facility on 09/16/16 with diagnoses that included diabetes mellitus, dementia, hemiplegia, and hypertension. Review of the most recent comprehensive Minimum Data Set (MDS) dated 07/18/16 revealed Resident #2 was cognitively intact and that her vision was adequate. The MDS also revealed that Resident #2 required extensive assistance of 2 staff members for bed mobility, transfers, and toilet use. In an observation and interview with Resident #2 on 09/28/16 at 4:03 PM Resident #2 was up in her wheelchair wearing her sunglasses in her room and was pacing the room anxiously with her eyebrows drawn and she appeared to be looking for something. When asked what was wrong, Resident #2 replied, "I am blind to a point and every time I leave my room they move my things around on my table, and I can't find my bowl that I keep all my personal stuff in." The bowl was observed sitting in a chair at the foot of Resident #2's bed and was pointed out to the resident. Resident #2 stated, "Yes, that is my red bowl that I have been looking for." Resident #2 was observed getting very close to the bowl to determine if it was the bowl she was seeking.	F 278	F278 1. Resident #2 was re-assessed by the RCMD regarding visual acuity on 10/6/16 and documented as visually impaired per resident. 2. All residents with visual impairments have the potential of being affected by this alleged deficient practice. An audit of all residents was completed by the Nurse Managers on 10/4/16 to identify those resident with visual impairments. The RCMD will ensure the next scheduled MDSs completed for those residents identified are coded correctly for visual acuity. These MDSs will be completed by 10/24/16. 3. The RCMD will re-educate the MDS Nurses on the accurate coding of visual acuity according to the RAI Manual. This re-education will be completed by 10/24/16. THE RCMD will monitor 5 MDSs completed weekly for 12 weeks to ensure accurate coding for visual acuity according to the RAI manual. Opportunities will be corrected as identified. 4. The RCMD will report the results of this monitoring to the QAPI committee monthly for 3 months and the committee will make recommendations as needed.	

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Resident #2 stated, "I looked for it but with my vision I could not see it." Resident #2 reached into the bowl and pulled out a small phone book and stated she was going to call her family. When asked if she could read the phone book Resident #2 replied, "No, I can ' t see the numbers. The staff has to look up the number and dial it for me." Resident #2 stated her eyesight was diminished due to a stroke years ago.

In an interview on 09/29/16 at 11:06 AM, the social worker (SW) stated she was responsible for completing the vision section of the MDS. She stated when she completed the vision question on the MDS, it was already answered as "adequate" and she just had to acknowledge the question. The SW stated she would verify the information based on the face to face interview with the resident when completing the MDS. The SW stated she was unaware of any visual impairment that Resident #2 had.

In an interview with the MDS coordinator on 09/29/16 at 11:09 AM she stated that vision on the comprehensive MDS was automatically populated from the point of care documentation that the Nursing Assistants (NAs) completed each shift. When the SW completed the vision section on the MDS she would verify the accuracy of the information based on her face to face interview with the resident. The MDS coordinator stated she was unaware of any visual impairment that Resident #2 had and she expected all staff that completed sections on the MDS to complete them accurately to reflect the resident.

In an interview with the Director of Nursing (DON) on 09/29/16 at 2:19 PM she revealed that she expected MDS assessments to be complete and

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F 278	Continued From page 14 accurate to reflect the resident's status. The DON stated she was unaware of any visual impairments that Resident #2 had.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to assess a resident for constipation when the resident went 6 days with no bowel movement (BM) for 1 of 3 residents reviewed for wellbeing (Resident #2). The findings included: Resident #2 was initially admitted to the facility on 07/08/16 and most recently readmitted to the facility on 09/16/16 with diagnoses that included diabetes mellitus, dementia, hemiplegia, hypertension, depression, anxiety, and psychosis. Review of the most recent comprehensive Minimum Data Set (MDS) dated 07/18/16 revealed that Resident #2 was cognitively intact and required extensive assistance of 2 staff members for bed mobility, transfers, and toilet use. The MDS also revealed that Resident #2 was always continent of bowel and constipation was not checked.	F 309	F309 1. Resident #2 is having bowel movements o a regular basis, the unit manager validated this on 9/29/16, resident did not complain of constipation. 2. All residents have the potential to be affected by this alleged deficient practice. The Nurse Managers conducted an audit of all current residents to validate effective monitoring and interventions related to resident's having Bowel Movements. This audit was completed by 10/3/2016. 3. Nurses and Nursing Assistants have been re-educated regarding the facility's policy for documenting, monitoring and intervening related to resident's Bowel Management. This re-education was completed by the Corporate Nurse and Nurse Managers by 10/24/16. Nurse Managers will randomly monitor 5 residents per week for 12 weeks to	10/24/16

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F 309	Continued From page 15 Review of a BM report dated 08/01/16 through 08/30/16 revealed that Resident #2 went from 08/12/16 to 08/17/16 with no BM recorded. Review of a physician order dated 08/17/16 read Dulcolax suppository insert 1 rectally one time a day for constipation. Review of a physician order dated 08/17/16 read Miralax powder 17 grams by mouth every day for constipation. Review of Medication Administration Record (MAR) dated 08/01/16 through 08/30/16 revealed that Resident #2 was given Dulcolax suppository rectally daily on 08/17/16 through 08/21/16 and received Miralax powder 17 grams by mouth daily from 08/17/16 through 08/21/16. Further review of the MAR revealed that the following medications that Resident #2 took may cause constipation aspirin, Crestor, gabapentin, levofloxacin, Risperdal, Zoloft, and tolterodine. Review of the nurse's notes from 08/12/16 through 08/17/16 revealed no record of a BM. Review of a nurse's note dated 08/18/16 at 7:05 AM read Resident #2 was afebrile. Antibiotic continued for urinary tract infection, no complaints of dysuria were voiced. Resident #2 had a BM this shift. On 09/28/16 at 12:10 PM Resident #2 was observed in the dining room, her meal ticket indicated she was on a diabetic diet and she had just finished her lunch and had eaten 75% of her meal and drank 75% of her fluids on the tray.	F 309	validate effective monitoring and interventions related to resident's Bowel Movements to ensure accurate documentation, assessment and intervention related to the bowel management regimen. Opportunities will be corrected as identified. 4.The DON will report the results of this monitoring to the QAPI committee monthly for 3 months and the committee will make recommendations as needed.	

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During an interview with Resident #2 on 09/28/16 at 12:20 PM she stated was able to tell when she needed to have a BM and usually she was able to take herself to the bathroom. Resident #2 stated at times she required assistance from staff. Resident #2 stated she was constipated occasionally but could not recall the specific time in August 2016 when she was constipated and did not have a BM for 6 days. Resident #2 stated that she had very recently been admitted to hospice services and they would start their weekly visits later in the week.

Interview with Nursing Assistant (NA) #3 on 09/28/16 at 3:00PM revealed that she assisted Resident #2 to the bathroom as she requested but a lot of the time Resident #2 would take herself. NA#3 stated that if Resident #3 took herself to the bathroom she did not always report when she had a BM, sometimes we would go back and ask her and sometime we would forget to. NA#3 stated Resident #2 was able to feed herself and ate and drank what she wanted. Usually Resident #2 ate pretty well and took fluids well if she liked the fluids that were offered or that were on her meal tray.

On 09/29/16 at 10:15 AM Resident #2 was observed lying in bed and had finished her breakfast tray and had eaten 100% of breakfast and had drank 75% of juice and coffee.

Interview with the Unit Manager on 09/29/16 at 12:42 PM revealed that all nurses were trained to review the dashboard in the electronic medical record and if a resident had gone 9 shifts with no BM they would appear on the dashboard. If a resident appeared on the dashboard for no BM in 9 shifts then the nurse was supposed to go and

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ask the NA's and the resident and see if they had a BM. If the resident stated they had a BM the staff was expected to make a note in the electronic medical record and if the resident did not have a BM or if the staff could not say that the resident had a BM they were to contact the physician. The unit manager stated she remembered this incident when Resident #2 had gone several days with no BM and she had asked the staff to look into the situation and they did not go back and document their findings. The unit manager stated that when Resident #2 had gone 9 shifts with no BM the nurse should have contacted the physician.

Interview with the Director of Nursing (DON) on 09/29/16 at 2:19 PM revealed that the nurses were expected to check the dashboard daily for residents that had gone 9 shifts with no BM and then contact the physician for further orders because the facility did not utilize standing physician orders. The DON stated she did not recall this particular incident with Resident #2 but would expect the nurses to have contacted the physician when Resident #2 had gone 3 days or 9 shift with no recorded BM.

Interview with Nurse #9 on 09/29/16 at 3:39 PM revealed that she routinely worked 2nd shift on Resident #2's unit. Nurse #9 stated that each afternoon she checked the dashboard in the electronic medical record to see which residents had gone 9 shift with no BM, then I go and ask the NAs if the resident had a BM. If the Resident did have a BM then I would disregard the dashboard and put it on the 24 hour report. If the resident had not had a BM, I would administer an as needed medication if they had one and if not then I would contact the physician. Nurse #9

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F 309	Continued From page 18 recalled this incident with Resident #2 and stated she had been off for a few days and when she returned on 08/17/16 the NAs informed her that Resident #2 had not had a BM so I contacted the physician and implemented those orders. Nurse #9 stated she did not remember if Resident #2 had appeared on the BM report on the dashboard after 9 shifts or not but if she had she would have given her something and documented in on the MAR. Interview with Nurse #10 on 09/29/16 at 4:24 PM revealed that she had only worked at the facility for 2 days on the day shift and did not recall this patient or the incident of Resident #2 not having a BM for 6 days.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide oral care for 1 of 3 sampled residents reviewed for Activities of Daily Living (ADL) (Resident #10). The findings included: Resident #10 was initially admitted to the facility on 05/20/16 and most recently readmitted on 06/29/16 with diagnoses that include dementia,	F 312	F312 1. Resident #10 was given mouth care by Certified Nursing Assistant on 9/28/16 2. All residents who require assistance with oral care have the potential to be affected by this alleged deficient practice. An audit was conducted by the Nurse Manager to identify residents in need of assistance with oral care and ensure completion. This audit was completed on	10/24/16

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F 312	Continued From page 19 weakness, Parkinsonism, and Alzheimer ' s disease. Review of the most recent quarterly Minimum Data Set (MDS) dated 08/16/16 revealed that Resident #10 was severely cognitively impaired and required extensive assistance with personal hygiene. The MDS also revealed that Resident #10 had physical and verbal behaviors that occurred 1 to 3 days during the review period. Review of Resident #10's current care plan, which was initiated on 01/23/16, read in part that Resident #10 was resistive to care and refused oral care at times. The goal of stated care plan was that Resident #10 would cooperate with care through the next review period. Interventions of the care plan included: allow Resident #10 to make decisions about her treatment regime and provide a sense of control, encourage as much participation/interaction by the resident as possible during care, and give clear explanation of all care activities prior to and as they occurred during each contact. During an observation of morning ADL care for Resident #10 on 09/28/16 at 10:20 AM. Nursing Assistant (NA) #3 was observed to enter the resident's room and assist Resident #10 to the bathroom and transferred her to the toilet. Once on the toilet NA#3 washed and dried Resident #10 from head to toe, provided incontinent care, replaced Resident #10's brief, and transferred Resident #10 from commode back to wheelchair. Resident #10 was then dressed appropriately for weather. NA#3 combed Resident #10's hair and turned on her chair alarm. NA#3 then took Resident #10 out in the hallway to retrieve a portable oxygen tank. NA#3 confirmed that she was finished with Resident #10's morning ADL	F 312	9/28/16. 3. Nursing Staff including CNAs were re-educated by Corporate Nurse and Facility Nursing Managers on techniques for completing oral care to include using a tooth brush to clean the mouth, teeth, gums and tongue. and cleaning dentures when in use. Oral care will be completed daily and as needed or based on the resident’s preference. This re-education was completed on October 7, 2016. The Nurse Managers will randomly observe 5 Resident Care Specialists per week for 12 weeks to ensure the completion of oral care for residents who need assistance including using a tooth brush to clean the mouth, teeth, gums and tongue. and cleaning dentures when in use. Opportunities will be corrected as identified. 4. The DON will report the results of this monitoring to the QAPI committee monthly for 3 months and the committee will make recommendations as needed.	

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F 312	Continued From page 20 care. Resident #10 was then taken to the day room and her portable oxygen tank placed on her chair. Resident #10's teeth were visible dirty with white substances at gum line and dried matter to teeth. During this observation of care Resident #10 required lots of encouragement to complete the care but was not resistive to the care. Observation of Resident #10's bathroom on 09/28/16 at 10:20 AM revealed 4 tubes of toothpaste but no toothbrush was located. Interview on 09/28/16 at 3:00 PM with NA#3 revealed that she routinely cared for Resident #10. NA#3 stated that she took Resident #10 to the shower on Monday and Thursday as long as the resident would allow it. NA#3 stated that Resident #10 was able to brush her teeth at times as long as she set her up. NA#3 stated that she did not brush Resident #10's teeth during the morning of 09/28/16 nor did she offer to brush the resident's teeth. NA#3 provided no explanation to why she did not brush the resident's teeth or offer to brush her teeth. Interview with Director of Nursing (DON) on 09/28/16 at 4:33 PM revealed that she expected the staff of perform oral care to residents during their morning care and at night if possible. The DON stated she expected the staff to perform oral care for Resident #10 during her morning care as the resident would allow.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		10/24/16

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F 314	Continued From page 21 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide physician ordered treatment for a pressure ulcer for 1 of 3 sampled residents (Resident #7). The findings included: Resident #7 was admitted to the facility on 7/1/16 with diagnosis that included acute respiratory failure, pressure ulcer of sacral region, dementia, atrial fibrillation, and anxiety. An admission Minimum Data Set (MDS) dated 7/8/16 indicated the resident was cognitively intact at time of assessment, required extensive to total assist with activities of daily living (ADL), and had multiple pressure ulcers found on admission. A care plan initiated on 7/12/16 indicated resident #7 had pressure ulcers to sacrum since admission and potential for pressure ulcers due to history of ulcers, immobility, and incontinence. The goal was for resident's pressure ulcer to show signs of healing and remain free from infection through review date. Interventions included to administer treatments as ordered and observe for effectiveness.	F 314	F314 1. Wound care including dressing application was completed for Resident 3 by Wound Nurse on 9/29/16. 2. Residents receiving wound care for treatment of pressure ulcers have the potential to be affected by this alleged deficient practice. An audit was conducted by the Nurse Managers to identify those residents with orders to treat pressure ulcers to identify those without treatment application as ordered. This audit was completed on 9/30/16. Discrepancies in treatment application were corrected by the Nurse Managers and wound nurse on 10/07/16. 3. Licensed Nurses were re-educated by Corporate Nurse and Facility Nurse Managers, regarding applying physician ordered treatments to residents with pressure ulcers. This re-education included the re-application of dislodged or removed treatments following the initial application. This re-education was completed by 10/7/16. The Nurse Managers will randomly observe 5 residents weekly for 12 weeks to ensure residents with pressure ulcers have the correct physician ordered treatments	

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F 314	Continued From page 22 A treatment sheet for resident #7 dated September 2016 indicated for wound care to sacrum with wet to dry dressing and border gauze every day and as needed (PRN) every day. The treatment sheet revealed wound care on 9/27/16 at 9:00AM. No PRN wound care was noted on the treatment sheet. The physician order sheet dated September 2016 indicated for wound care to sacrum with wet to dry dressing and border gauze every day and PRN every day. A wound care consult sheet dated 9/23/16 revealed to continue wet to moist dressing once daily to Stage 4 pressure wound of the left sacrum. On 9/28/16 10:55 AM observation of resident #7 wound care of sacrum pressure ulcer with wound nurse #1 revealed no dressing over sacral wound. Resident's wound was covered with brief only. No signs of incontinence noted to brief. The wound nurse stated "Did you make note of that? There was no dressing on her bottom." On 9/28/16 11:10 AM an interview with wound nurse #1 revealed that when she came to work on the morning of 9/27/16 and 9/28/16 there was no dressing on resident's #7 sacral wound. The wound nurse further stated that when the resident's dressings came off during the day or night, the nurses was supposed to replace the dressings. The wound nurse indicated that the sacral wound to resident #7 was healing and had improved since admission. 9/28/16 2:30 PM Nurse Aide #1 stated at 7:15 AM she noted that resident #7 dressing was not on	F 314	applied and in place. Opportunities will be corrected as identified. 4.The DON will report the results of this monitoring to the QAPI committee monthly for 3 months and the committee will make recommendations as needed.	

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F 314	Continued From page 23 her sacral wound so she notified a nurse that was new. She further indicated the new nurse stated she would notify the wound nurse to replace the dressing. The nurse aide indicated the nurse did not replace the dressing on resident #7. 9/28/16 2:35 PM An interview with nurse #2 responsible for the care of resident #7 revealed he was unaware that resident #7 did not have a dressing on her wound. The nurse stated the nurse aides was supposed to notify him if a dressing came off a resident that needed to be replaced. The nurse went on to say when a resident's dressing needed to be replaced he was supposed to change the dressing or he would notify the wound nurse to replace the dressing. 9/28/16 2:39 PM An interview with nurse #3 who worked on the hall with nurse #1 stated she did not recall a nurse aide notifying her that resident #7 dressing to her sacrum needed to be replaced. The nurse also stated she did not take care of resident #7. Nurse #3 indicated that a resident's wound dressing would be replaced by the floor nurse if the wound nurse was unavailable. 9/29/16 1:22 PM An interview with the DON revealed that she expected for the nurse aide to report to the nurse when a resident's dressing needed to be replaced. The DON went on to say if a resident's dressing needed to be replaced the nurse should notify the wound nurse if available and if not replace the dressing themselves.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		10/24/16

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F 323	Continued From page 24 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, physician interviews and record review the facility failed to use a mechanical lift to provide a safe transfer which resulted in multiple fractures for 1 of 3 sampled residents (Resident #3). The findings included: Resident #3 was admitted to the facility on 07/06/12 with diagnoses that included stage 4 pressure ulcer, morbid obesity and anxiety. The Minimum Data Set (MDS) dated 04/27/16 specified the resident had moderately impaired cognition and was transferred with a mechanical lift and had not fallen. A care area assessment dated 05/05/16 specified Resident #3 required extensive assistance with turning, repositioning, bed mobility, transfers and toilet use; and the resident was to have two staff for transfers. A care plan revised on 05/17/16 identified Resident #3 had limited physical mobility related to morbid obesity and was to be transferred via mechanical lift with two person assistance with all transfers.	F 323	Past noncompliance: no plan of correction required.	

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Review of Resident #3's medical record revealed a document titled "SBAR (Situation Background Assessment Recommendation) Communication Form" dated 05/19/16 that read in part, Resident #3 fell to the floor when nurse aide (NA) #1 transferred the resident. The form indicated the physician was contacted and ordered the resident be sent to the Emergency Department for evaluation. Resident #3 was admitted to the hospital.

The Hospital Discharge Summary dated 05/26/16 specified the resident fell when she was "accidently dropped" and sustained an acute left distal femoral fracture, and a proximal fibula-tibia and plateau fractures. The fractures were unable to be corrected with surgery. Resident #3 was readmitted to the facility on 05/26/16.

On 09/28/16 at 11:47 AM observations were made of Resident #3 in bed. Resident #3 stated she did not want to get out of bed because her leg was "bothering her." Resident #3 did not request to get out of bed during the survey but she stated the nurse aides used the mechanical lift to transfer her.

On 09/29/16 at 9:42 AM the physician was interviewed on the telephone and explained he was the facility's medical director and responsible for everyone in the building and expected staff to follow a resident's plan of care.

On 09/29/16 at 12:35 PM NA #1 was interviewed and explained she was assigned to work with Resident #3 on 05/19/16 for the first time. NA #1 stated she was not aware of how Resident #3 transferred and asked another nurse aide. NA #1 added she did not check Resident #3's plan of

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care but decided to stand and pivot the resident. She stated that once the resident stood up, her legs buckled and she fell to the floor crushing her left leg underneath the weight of her body. The NA stated that she was immediately disciplined and educated to follow a plan of care for transferring residents.

On 09/29/16 at 10:35 AM the Director of Nursing (DON) was interviewed and reported that Resident #3 fell on 05/19/16, fractured her leg as result of being transferred incorrectly. The DON explained that NA #1 was assigned to care for Resident #3 for the first time on 05/19/16. Rather than reviewing Resident #3's plan of care, NA #1 asked an agency nurse aide (not a facility staff member) how to transfer Resident #3. According to the DON, the agency nurse aide told NA #1 to stand and pivot Resident #3. NA #1 followed the agency nurse aide's directions, attempted to stand and pivot Resident #3; Resident #3 fell to the floor and was injured. The DON stated she was made aware of the situation and immediately implemented corrective measures through a "Performance Improvement Plan (PIP)." The DON added that at the time of the incident the facility was already out of compliance for F 323 (Supervision to prevent accidents). The DON reported she had conducted in-service education to all staff and monitored transfers to ensure they were being performed correctly.

The facility provided credible evidence of the corrective measure implemented after the incident. The measures included:
- Disciplinary action for NA #1 and education of how to transfer Resident #3.
- Audits of all residents to validate transfer status 05/19/16.

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F 323	Continued From page 27 - Education to all staff regarding safe transfers dated 05/22/16 o Always refer to assignment sheet for directions on transfer methods o If you have questions regarding the information on the assignment sheet ask a nurse and/or nurses supervisor o Do not rely on other staff for care instructions other than the nurse and/or nurses supervisor o Always review the assignment sheet prior to beginning your assignment o If a resident is to be transferred with a mechanical lift, use the mechanical lift - Monitoring by administrative nurses and floor nurses of staff transferring residents started on 05/22/16 and ongoing. Monitoring included weekly audits of staff transferring residents to ensure that safe technique was being used and the nurse aides were following each resident's assignment sheet. - Audits are reviewed by the Director of Nursing weekly and presented to the Quality Improvement Committee. During the investigation validation of the corrective measures through interviews with staff, observations and record review indicated the facility had implemented measures to prevent repeat deficient practice. Observations were made of residents being transferred including the use of a mechanical lift and no concerns were identified. Based on review of the facility ' s monitoring documentation, resident interview, staff interviews and observations, the facility was placed back in compliance effective 06/06/16.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		10/24/16

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F 431	Continued From page 28 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident interview and staff interviews, the facility failed to implement an effective system with sufficient	F 431	F431 1. The Director of Nursing immediately obtained replacement medications for	

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F 431	Continued From page 29 detail to account for the receipt, usage, and reconciliation of all controlled medications according to facility procedures to prevent and identify the diversion/loss of controlled substance for 1 of 3 sample residents (Resident #16). The findings included: Resident #16 was admitted to the facility on 08/10/2016. Her diagnoses included high blood pressure, Diabetes Mellitus, hemiplegia, and chronic pain. The most recent Minimum Data Set dated 09/11/2016 coded Resident #16 as cognitively intact, having clear speech with adequate vision and hearing. A review of Resident #16's care plan dated 08/21/2016 revealed that she had pains related to the fracture of left pubic and sacrum resulted from a fall prior to her admission to the facility. The goal of the pain therapy was for Resident #16 to have adequate relief of pain. Interventions included anticipated Resident #16's needs for pain relief and responded immediately to complaint of pain. Review of Pharmacy packing slips and facility's receipts for controlled drugs revealed that the following shipments of Oxycodone with Acetaminophen (Percocet) 5/325 milligrams (mg) for Resident #16 had been delivered by the pharmacy and received/signed by the facility staff: · 08/10/2016; Quantity = 60 tablets; Shipping number - 519224 · 09/20/2016; Quantity = 30 tablets; Shipping number - 528002 The facility had received a total of 90 tablets of Percocet 5/325 mg for Resident #16 since her	F 431	resident #16 on 9/28/16 2. All residents receiving controlled substance have the potential of being affected by this alleged deficient practice. The Director of Nursing and Nurse Managers conducted an audit of narcotic sign out logs for residents receiving controlled substances to validate an accurate count of these medications. Any discrepancies identified were corrected by replacing the medications. This audit was completed on 9/30/16. 3. Licensed Nurses will be re-educated on the facility's policy for storage and labeling of medication to include monitoring and securing controlled substances. 2 Nursing staff members will sign the narcotic count sheet with blister packs. Count sheets will be reconciled per shift. The Director of Nursing and Nurse Managers will randomly audit the controlled substance monitoring sheets for 10 residents weekly for 12 weeks then monthly for 9 months to validate accurate storage and monitoring. Opportunities will be corrected as identified. 4. The DON will report the results of this monitoring to the QAPI committee monthly for 12 months to ensure ongoing adherence and the committee will make recommendations as needed if opportunities are identified.	

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admission on 08/10/2016.

Review of physician's order dated 08/10/2016 revealed that Resident #16 was prescribed with the following two pain medications:
· Percocet 5/325 mg, one tablet by mouth every six hours as needed for pain,
· Gabapentin 100 mg, one capsule by mouth three times daily for pain.

Review of Resident #16's electronic Medication Administration Records (eMAR) revealed that she had taken 3 tablets of Percocet 5/325 mg in August, 2016; and 10 tablets in September by 09/29/2016. Each tablet of Percocet administered by the nurse was charted in the eMAR with nurses' initial, date and time of administration, and its effectiveness.

Review of the facility staff roster for 100 Hall revealed that Nurse #4 was working on 09/27/2016 from 3 to 11 PM. Nurse #5 who took over the shift on 09/27/2016 was working from 11 PM to 7 AM. The next shift was covered by Nurse #6 on 09/28/2016 from 7 AM to 3 PM. Then, the shift was transitioned to Nurse #4 again on 09/28/2016 at 3 PM.

Observation of medication carts for 200 Hall on 09/29/16 at 3:02 PM, 300 Hall at 3:11 PM, and 100 Hall at 3:20 PM revealed that there were 2 locked compartments for controlled drugs for each cart. The top locked compartment stored controlled drugs that were currently in use by the residents. The bottom locked compartment was for back-up controlled drugs. Each card of controlled drugs in the top locked compartment could be tracked with a Declining Inventory Count Sheet (DICS) that included the name of resident,

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name of controlled drug, date and time of administration, and the declining balance. In addition, each locked compartment had a copy of " Controlled Drugs-count Record " (CDR) to track the balance of the controlled drug cards. The CDRs consisted of 2 columns each shift for the nurses to sign off during the shift transition to serve as an acknowledgement of a successful reconciliation. There was a " Comments " column at the far right with no entries observed for the top locked compartment for 100 Hall medication cart except a single number of " 27 " appeared on 09/28/2016. For the bottom locked compartment, the " comment " column consisted of some random numbers that failed to track the actual balance of controlled drug cards in the locked compartment. No columns were designed to track and record the balance of controlled drug cards for both locked compartments.

In a phone interview conducted on 09/29/2016 at 11:20 AM, Nurse #4 stated that she assumed the shift from Nurse #6 at 3:00 PM on 09/28/2016. During the shift transition, she matched all the DICS for each card of controlled drugs in the top locked compartment and counted the total number of controlled drug cards in the bottom locked compartment. She found no discrepancies according to the balance shown on bottom locked compartment CDR sheet. However, she did not count, verify, track, and record the total number of medication cards for the top locked compartment. When Resident #16 requested the Percocet on 09/28/16 at around 3:45 PM, Nurse #4 found that the whole card of Percocet 5/325 mg was missing. Nurse #4 recalled she had given Resident #16 Percocet 5/325 mg a day before and it should have at least 26 pills remained in the card. According to Nurse #4,

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Resident #16's Percocet were in the medication cart when she transitioned the shift to Nurse #5. She alerted Nurse #8 who was the Unit Manager to help searching for the missing controlled drugs but they were unable to find the missing Percocet. Nurse #4 had to retrieve the Percocet later from the Pixel.

In a phone interview attempted on 09/29/2016 at 1:03 PM, Nurse #6 did not answer or return the call.

In an interview conducted on 09/29/2016 at 1:08 PM, Resident #16 stated that she had history of pain at her left lower extremity. She needed approximately 2 tablets of Percocet per week and it had been effective for her pain relief. She had one tablet of Percocet on 09/27/2016 around 8:30 PM and the next tablet on 09/28/2016 around 4:30 PM. She remembered both pain pills were administered by the same nurse.

On 09/29/2016 at 1:08 PM, Resident #16 was observed having no signs or symptoms of pain or discomfort.

In an interview conducted on 09/29/2016 at 1:20 PM, Nurse #8 stated that the incident of missing Percocet 5/325 mg was reported to her by Nurse #4 on 09/28/2016 around 4:15 PM. Nurse #4 told her that she had given Resident #16 one tablet of Percocet 5/325 mg the night before and at least 26 pills should be remained in the top locked compartment. During the investigation, Nurse #8 found that the DICS for Resident #16's Percocet 5/325 mg was also missing. With the assistance of the consultant pharmacist, Nurse #8 confirmed that Resident #16 had used 13 tablets of Percocet 5/325 mg since her admission on

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08/10/2016. 1 of the 13 tablets was retrieved from the Pixel. The pharmacy had delivered a total of 90 tablets Percocet 5/325 mg for Resident #16 so far. A total of 78 tablets of Percocet 5/325 mg for Resident #16 were missing. Once Nurse #8 confirmed the missing of Percocet, she reported the incident to the Director of Nursing (DON) around 5:00 PM on 09/28/2016.

In an interview conducted on 09/29/2016 at 3:40 PM, the consultant pharmacist stated when she realized that the DICS for Resident #16's Percocet 5/325 mg and the medication were both missing, she suspected that it was a deliberate action to embezzle the controlled drugs from the facility. According to the consultant pharmacist, even without the DICS, the facility should still be able to identify the missing of the controlled medication immediately if the nurses had verified, tracked, and documented the balance of controlled drug cards in the CDRs for both locked compartments during shift transition. She stated the CDRs should have columns designated to track and record the balance of controlled drug cards in the cart. The facility had failed to implement and enforce the policy and procedures of reconciling, verifying, and documenting all the controlled drug cards in the cart during shift transition.

In a phone interview conducted on 9/30/2016 at 4:16 PM, Nurse #5 stated that during the shift change on 09/27/2016 at 7:00 AM, she matched each controlled drug cards with its DICS for the top locked compartment and counted the total number of controlled drug cards for the bottom locked compartment. She found no discrepancies for both locked compartment. However, she did not count and record the total number of

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F 431	Continued From page 34 controlled drug cards for the top locked compartment. In an interview conducted on 09/29/2016 on 3:20 PM, the DON stated that all controlled drugs in the top locked compartment must have a DICS with matching prescription numbers. It was her expectation for all the nurses to fill out the DICS each time when they dispensed controlled drugs and to verify, track, and document the balance of controlled drug cards in the CDRs for both locked compartments during shift transition. Once the nurse signed the CDRs during shift transition, he/she would be accountable for the controlled drugs until the medication cart signed over to another nurse. According to the DON, the nurses had failed to verify, track, and document the balance of the medication cards for both locked compartments in the 100 Hall medication cart during shift transitions and lead to the missing of 78 tablets of Percocet 5/325 mg.	F 431		