STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING _____ B. WING _____	C 09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	**610 WEST FISHER STREET SALISBURY, NC 28145**

(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 No deficiencies were cited as a result of the complaint investigation. Event ID #1YLS11.	F 000		
F 278 SS=B	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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 278	THIS FACILITY□S RESPONSE TO THIS	10/1/14

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

Electronically Signed | 10/06/2014

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F 278	Continued From page 1 facility failed to accurately code the Minimum Data Set (MDS) to reflect results of the Level II Preadmission Screening and Resident Review (PASRR) determination for 4 of 8 residents identified as Level II PASRR residents (Resident #36, Resident #11, Resident #14 and Resident #24). The findings included: 1) Resident #36 was initially admitted to the facility on 10/25/12 and re-admitted on 7/18/14 with cumulative diagnoses which included bipolar mood disorder. A review of Resident #36 ' s Minimum Data Set (MDS) assessment (Section A) dated 8/14/14 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. Determination of a Level II PASRR resident is made by an in-depth evaluation. The results of this evaluation are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility ' s list of Level II PASRR residents revealed that Resident #36 was included among the residents named on the list. A review of Resident #36 ' s records included a Level II PASRR written verification of approval from the state dated 1/13/14. Resident #36 ' s Level II PASRR number included the letter code " B. "	F 278	REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. " F:278 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 09/17/2014 Resident #36, Resident #11, Resident #14, and Resident #24 were reviewed by the MDS Nurse, Clinical Services Supervisor, and Administrator along with the other residents to ensure that the MDS accurately reflects their Level 2 PASSR information on the MDS. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the potential to be affected by this practice. On 09/17/2014 Resident #36, Resident #11, Resident #14, and Resident #24 were reviewed by the MDS Nurse, Clinical Services Supervisor, and Administrator along with the other residents to ensure that the MDS accurately reflects their	

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F 278	Continued From page 2 An interview was conducted on 9/17/14 at 3:45 PM with Nurse #3. Nurse #3 assumed responsibility for completion of the facility ' s Minimum Data Set (MDS) assessments and care plans. During the interview, Nurse #3 reported that she typically looked at the PASRR letter code at the bottom of each resident ' s face sheet to determine whether or not a resident was determined to be a Level II PASRR. She noted that any letter code other than an " A " was a flag that the resident would need to be coded on the MDS as a Level II PASRR. Upon further inquiry, the nurse indicated that the only other way she would know if a resident was a Level II PASRR was through communication with other staff members. Nurse #3 stated, " I don ' t get an official report. " An interview was conducted on 9/17/14 at 3:54 PM with the Clinical Nurse Supervisor. The Clinical Nurse Supervisor assumed responsibility for receiving PASRR information for residents, processing this information through the state, and subsequently receiving verification and approval. Upon inquiry, the Clinical Nurse Supervisor indicated she was not aware that the Level II PASRR information needed to be communicated to the MDS Nurse. She reported that she thought the processing information from the State was linked to the MDS information so that it would automatically populate and code the resident as a Level II PASRR, when appropriate. An interview was conducted on 9/17/14 at 4:22 PM with the facility ' s Administrator. Upon inquiry, the Administrator indicated that her expectation was for the Level II PASRR determination to be coded accurately on each resident ' s MDS assessment.	F 278	Level 2 PASRR information on the MDS. On 09-17-14, the facility Administrator re-educated the Clinical Services Supervisor, and MDS Nurse concerning any resident that has a Level 2 PASRR currently and any new admissions will be communicated to the MDS Coordinator and Administrator by the Clinical Services Supervisor to ensure the MDS is coded correctly. They both were also given the list of Authorization Codes and Corresponding Timeframes/Restrictions from the NC Provider Manual to ensure both understood what a Level II Code Letter represents. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: On 09-17-14, the facility Administrator re-educated the Clinical Services Supervisor, and MDS Nurse concerning any resident that has a Level 2 PASRR currently and any new admissions will be communicated to the MDS Coordinator and Administrator by the Clinical Services Supervisor to ensure the MDS is coded correctly. They both were also given the list of Authorization Codes and Corresponding Timeframes/Restrictions from the NC Provider Manual to ensure both understand what a Level II Code Letter represents.	

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F 278	Continued From page 3 2) Resident #11 was admitted to the facility on 6/3/2004 with cumulative diagnoses which included intellect disability. A review of Resident #11 ' s Minimum Data Set (MDS) assessment (Section A) dated 8/11/14 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. Determination of a Level II PASRR resident is made by an in-depth evaluation. The results of this evaluation are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility ' s list of Level II PASRR residents revealed that Resident #11 was included among the residents named on the list. A review of Resident #11 ' s records revealed the resident had been assigned a Level II PASRR number/letter code. Resident #11 ' s Level II PASRR number included the letter code " B. " An interview was conducted on 9/17/14 at 3:45 PM with Nurse #3. Nurse #3 assumed responsibility for completion of the facility ' s Minimum Data Set (MDS) assessments and care plans. During the interview, Nurse #3 reported that she typically looked at the PASRR letter code at the bottom of each resident ' s face sheet to determine whether or not a resident was determined to be a Level II PASRR. She noted that any letter code other than an " A " was a flag that the resident would need to be coded on	F 278	The facility has created an audit form called the MDS PASRR Audit. This audit will be used for every Resident upon completion of each MDS assessment to ensure that each PASRR has been coded correctly and will be completed by the facility Administrator/Designee. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The facility has created an audit form called the MDS PASRR Audit. This audit will be used for every Resident upon completion of each MDS assessment to ensure that each PASRR has been coded correctly and will be completed by the facility Administrator/Designee. The QA Committee will review the MDS Audit weekly to evaluate the facility□s progress toward implementation of corrective action(s) and the facility□s	

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F 278	Continued From page 4 the MDS as a Level II PASRR. Upon further inquiry, the nurse indicated that the only other way she would know if a resident was a Level II PASRR was through communication with other staff members. Nurse #3 stated, " I don ' t get an official report. " An interview was conducted on 9/17/14 at 3:54 PM with the Clinical Nurse Supervisor. The Clinical Nurse Supervisor assumed responsibility for receiving PASRR information for residents, processing this information through the State, and subsequently receiving verification and approval. Upon inquiry, the Clinical Nurse Supervisor indicated she was not aware that the Level II PASRR information needed to be communicated to the MDS Nurse. She reported that she thought the processing information from the state was linked to the MDS information so that it would automatically populate and code the resident as a Level II PASRR, when appropriate. An interview was conducted on 9/17/14 at 4:22 PM with the facility ' s Administrator. Upon inquiry, the Administrator indicated that her expectation was for the Level II PASRR determination to be coded accurately on each resident ' s MDS assessment. 3) Resident #14 was admitted to the facility on 8/6/12 with cumulative diagnoses which included traumatic brain injury. A review of Resident #14 ' s Minimum Data Set (MDS) assessment (Section A) dated 6/2/14 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability.	F 278	performance to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	

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F 278	Continued From page 5	F 278		

Determination of a Level II PASRR resident is made by an in-depth evaluation. The results of this evaluation are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.

A review of the facility ' s list of Level II PASRR residents revealed that Resident #14 was included among the residents named on the list.

A review of Resident #14 ' s records included a Level II PASRR written verification of approval from the state dated 1/21/14. Resident #14 ' s Level II PASRR number included the letter code " B. "

An interview was conducted on 9/17/14 at 3:45 PM with Nurse #3. Nurse #3 assumed responsibility for completion of the facility ' s Minimum Data Set (MDS) assessments and care plans. During the interview, Nurse #3 reported that she typically looked at the PASRR letter code at the bottom of each resident ' s face sheet to determine whether or not a resident was determined to be a Level II PASRR. She noted that any letter code other than an " A " was a flag that the resident would need to be coded on the MDS as a Level II PASRR. Upon further inquiry, the nurse indicated that the only other way she would know if a resident was a Level II PASRR was through communication with other staff members. Nurse #3 stated, " I don ' t get an official report. "

An interview was conducted on 9/17/14 at 3:54 PM with the Clinical Nurse Supervisor. The Clinical Nurse Supervisor assumed responsibility

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F 278	Continued From page 6	F 278		

for receiving PASRR information for residents, processing this information through the state, and subsequently receiving verification and approval. Upon inquiry, the Clinical Nurse Supervisor indicated she was not aware that the Level II PASRR information needed to be communicated to the MDS Nurse. She reported that she thought the processing information from the State was linked to the MDS information so that it would automatically populate and code the resident as a Level II PASRR, when appropriate.

An interview was conducted on 9/17/14 at 4:22 PM with the facility ' s Administrator. Upon inquiry, the Administrator indicated that her expectation was for the Level II PASRR determination to be coded accurately on each resident ' s MDS assessment.

4) Resident #24 was initially admitted to the facility on 11/25/11 and re-admitted on 5/2/14 with cumulative diagnoses which included schizophrenia.

A review of Resident #24 ' s Minimum Data Set (MDS) assessment (Section A) dated 7/21/14 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. Determination of a Level II PASRR resident is made by an in-depth evaluation. The results of this evaluation are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.

A review of the facility ' s list of Level II PASRR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 7	F 278		

residents revealed that Resident #24 was included among the residents named on the list.

A review of Resident #24 ' s records revealed the resident had been assigned a Level II PASRR number/letter code. Resident #24 ' s Level II PASRR number included the letter code " B. "

An interview was conducted on 9/17/14 at 3:45 PM with Nurse #3. Nurse #3 assumed responsibility for completion of the facility ' s Minimum Data Set (MDS) assessments and care plans. During the interview, Nurse #3 reported that she typically looked at the PASRR letter code at the bottom of each resident ' s face sheet to determine whether or not a resident was determined to be a Level II PASRR. She noted that any letter code other than an " A " was a flag that the resident would need to be coded on the MDS as a Level II PASRR. Upon further inquiry, the nurse indicated that the only other way she would know if a resident was a Level II PASRR was through communication with other staff members. Nurse #3 stated, " I don ' t get an official report. "

An interview was conducted on 9/17/14 at 3:54 PM with the Clinical Nurse Supervisor. The Clinical Nurse Supervisor assumed responsibility for receiving PASRR information for residents, processing this information through the state, and subsequently receiving verification and approval. Upon inquiry, the Clinical Nurse Supervisor indicated she was not aware that the Level II PASRR information needed to be communicated to the MDS Nurse. She reported that she thought the processing information from the State was linked to the MDS information so that it would automatically populate and code the resident as

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F 278	Continued From page 8 Level II PASRR, whenever appropriate. An interview was conducted on 9/17/14 at 4:22 PM with the facility ' s Administrator. Upon inquiry, the Administrator indicated that her expectation was for the Level II PASRR determination to be coded accurately on each resident ' s MDS assessment.	F 278		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431		10/1/14

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F 431	Continued From page 9 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 observations, medical records and staff interviews, the facility failed to discard expired medications as specified by the drug manufacturer in 1 of 2 medication store rooms (100/200 Hall); and failed to have a system in place to ensure a resident ' s home medications were appropriately and securely stored for 1 of 1 residents (Resident #40). 1) An observation of the 100/200 hall medication store room on 9/18/14 at 2:32 PM revealed an opened vial of Aplisol Tuberculin PPD (an injectable medication used as a screening test for tuberculosis) was stored in the refrigerator. The vial was not labeled with the date it had been opened. The pharmacy label on the vial indicated that the Aplisol had been dispensed to the facility on 7/14/14. The manufacturer ' s product information indicated opened vials of Aplisol should be discarded after 30 days. During an interview with Nurse #1 on 9/18/14 at 2:35 PM, the nurse indicated the opened vial should have been labeled with the date it was opened on the outside of the vial. Nurse #1 stated this vial would need to be discarded since it was not known when it had been opened. During an interview with the Director of Nursing (DON) on 9/18/14 at 2:50 PM, the DON	F 431	THIS FACILITY□S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. " F:431 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: An audit was completed on 09-17-14 to ensure all open medication vials were labeled and dated. No others were found unlabeled. All nurses have been re-educated on 09-17-14,09-18-14, and 09-29-14 by the Director of Nursing on proper labeling of open medications. On 09-17-14 and 09-18-14 the Director of Nursing and Clinical Services Supervisor inspected the two (2) medication rooms to ensure no home medications and/or	

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F 431	Continued From page 10 addressed the normal procedure for dating and storing medications such as Aplisol. The DON reported the Aplisol vial should have been dated when opened. In a follow-up interview conducted on 9/18/14 at 2:55PM, the DON indicated that she had contacted the facility ' s pharmacy regarding the expiration of an opened vial of Aplisol. The pharmacy confirmed that a vial of Aplisol expired 30 days after opening. 2) An observation of the 100/200 hall medication store room refrigerator on 9/18/14 at 2:32 PM revealed an opened vial of Pneumovax-23 (an injectable vaccine) was labeled with a manufacturer ' s expiration date of 8/22/14. Pneumovax-23 product information indicated all vials should be discarded after the manufacturer ' s expiration date. During an interview with Nurse #1 on 9/18/14 at 2:35 PM, the nurse indicated the vial of Pneumovax-23 should have been discarded by the expiration date. Nurse #1 stated this vial would need to be discarded. During an interview with the Director of Nursing (DON) on 9/18/14 at 2:55 PM, the DON indicated that she had contacted the facility ' s pharmacy regarding the expiration of Pneumovax-23. The pharmacy confirmed that both unopened and opened vials of Pneumovax-23 expired upon the manufacturer ' s expiration date. 3) Resident #40 was admitted to an acute care hospital on 7/29/14. Resident #40 was transferred from the hospital for admission to the facility on 8/1/14. Her cumulative diagnoses included superior and inferior left pubic ramus fracture (pelvic fracture), rheumatoid arthritis, and	F 431	home prescriptions were in the medication rooms. No others were found. All nurses have been re-educated on 09-17-14,09-18-14, and 09-29-14 by the Director of Nursing on Proper Drug Storage of home medications and or home prescriptions. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: An inspection was completed on 09-17-14 to ensure all open medication vials were labeled and dated by the Director of Nursing and the Clinical Services Supervisor. No others were found unlabeled. All nurses were educated on 09-17-14, 09-18-14 and 09-29-14 by the Director of Nursing on proper labeling of open medications. On 09-17-14 and 09-18-14 the Director of Nursing and Clinical Services Supervisor inspected the two (2) medication rooms to ensure no home medications and/or home prescriptions were in the medication rooms. No others were found. All nurses have been re-educated on 09-17-14,09-18-14, and 09-29-14 by the	

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	345140	A. BUILDING _____ B. WING _____	C 09/18/2014

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F 431	Continued From page 11 anxiety. A review of the resident ' s hospital records included a signed form entitled, " Medications Brought from Home Tracking Tool. " The tracking tool was signed by resident #40 on 8/1/14 to indicate the receipt of medications returned to her upon discharge from the hospital. The list of medications included: 9 prescription medications (which were not controlled substances and had no count of the quantity noted) with each medication stored in a separate container; 1 tablet of 0.5 milligrams (mg) clonazepam (a controlled substance used in the treatment of anxiety); 11 tablets of 20 mg Opana ER (a controlled substance which is an extended release formulation of oxymorphone used for moderate to severe pain); and 24 tablets of 15 mg oxycodone (a controlled substance which is an immediate release formulation of an opioid medication used for moderate to severe pain). The hospital Nursing Discharge Summary dated 8/1/14 noted the patient was given prescription medications to transport. An interview was conducted with the facility ' s Administrator on 9/16/14 at 4:43 PM. During this interview, the Administrator discussed the process of admitting a resident to the facility. Upon inquiry, the Administrator indicated that home medications brought into the facility would not be accepted by the facility and would be sent back home with loved ones. An interview was conducted with the facility ' s Administrative Assistant on 9/17/14 at 9:51 AM. The Administrative Assistant discussed the process of admitting a resident to the facility, which included taking an inventory of the resident ' s belongings. During the interview, the Administrative Assistant indicated that a resident	F 431	Director of Nursing on Proper Drug Storage of home medications and or home prescriptions. There are two (2) audit forms initiated by the Administrator to ensure the deficient practice does not recur. A. Med Inventory Audit, this form is completed on admission/re-admission by the Clinical Services Supervisor and DON to make sure all home medication and or home prescriptions are stored properly. B. Weekly Expired Medication Audit, this form is completed weekly by the Clinical Services Supervisor and DON to make sure all drugs are labeled properly. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: There are two (2) audit forms initiated by the Administrator to ensure the deficient practice does not recur. C. Med Inventory Audit, this form is completed on admission/re-admission by the Clinical Services Supervisor and DON to make sure all home medication and or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING _____ B. WING _____	C 09/18/2014

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F 431	Continued From page 12 was not allowed to keep home medications at the facility and reported that the nursing staff would give such medications to the family to take back home. Upon further inquiry, the Administrative Assistant indicated that Resident #40 reported bringing some home medications with her (from the hospital to the facility) upon admission. The Administrative Assistant stated that she herself, " just saw a bag ...you could hear pills in a bottle. " The Administrative Assistant reported, however, that she did not actually see the bottle(s) of pills. The Administrative Assistant also reported that Resident #20 ' s bag of home medications would have gone directly to the floor nurse and then to the Director of Nursing (DON) or Clinical Nursing Supervisor. An interview was conducted with the facility ' s DON on 9/17/14 at 10:18 AM. The DON recalled that when Resident #40 was admitted to the facility on 8/1/14, she had a bag of medications brought in with her. The DON stated that she told the resident the facility could not accept the medications and they needed to leave the facility. The DON reported that she herself put the bag of medications on a counter in the locked 200/300 medication store room. The DON indicated the medications remained on the counter of the medication store room until the resident was discharged from the facility (on 8/22/14). Upon inquiry, the DON reported that an inventory of the medications in the bag had not been taken. The DON stated she did not know the types or amounts of medications that were in the bag. An interview was conducted with Nurse #2 on 9/17/14 at 10:30 AM. Nurse #2 was a staff nurse who worked on the 200/300 hall. During the interview, Nurse #2 confirmed a bag of	F 431	home prescriptions are stored properly. D. Weekly Expired Medication Audit, this form is completed weekly by the Clinical Services Supervisor and DON to make sure all drugs are labeled properly. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The DON and Clinical Services Supervisor will complete Med Inventory Audit upon admission/ re-admission of each resident to the facility. The Expired Medication audit will be completed weekly. Any discrepancies noted will be followed by re-education with the nurses by the Director of Nursing. The QA Committee will review weekly, the facility□s progress towards implementation of corrective action(s) and the facility□s performance to ensure that corrective performance is achieved and sustained. The QA Committee will review	

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F 431	Continued From page 13 medications had been stored on the counter of the 200/300 medication store room for Resident #40 during her stay at the facility. Upon inquiry, the nurse stated she did not know what types or amounts of medications were in the bag. A follow-up interview was conducted with the Administrator on 9/17/14 at 10:42 AM. During this interview, the Administrator stated she was not aware that Resident #40 had brought home medications into the facility upon admission nor that these medications had been stored within the facility during her stay. Upon inquiry, the Administrator stated that her expectation was, "If those meds were in here, administration staff would have needed to go down and count out the meds with a staff nurse." The Administrator also indicated that an inventory should have made of all the medications and that the resident (if alert) should have been asked to sign off on the inventory confirming its accuracy and completeness. She indicated that an inventory of the medications would have been necessary to identify the proper means to store each medication. When asked where the medications should have been stored, the Administrator stated that all controlled substances would have needed to be stored behind two locks.	F 431	the facility□s progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	