STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345173	A. BUILDING _____ B. WING _____	C 09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD HEALTH & REHAB CENTER	**54 RED MULBERRY WAY LILLINGTON, NC 27546**

(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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to implement their neglect policy to assure a completed investigation was done and a 24 hour and 5 day report of the findings was submitted to the appropriate state agency when a scheduled nurse left the facility after reporting to work and whose absence from her job duties preceded a formal complaint to the facility that one (Resident # 2) out of 8 sampled residents went without medications because there had been no nurse on the hall during the nurse ' s scheduled shift. The findings included: Review of the facility ' s Resident Abuse policy, dated May 2008 and last revised on 4/16/15, revealed that it is the facility ' s policy to investigate all allegations or suspicions of Neglect and that in an effort to prevent and identify abuse or neglect the facility will deploy staff on each shift in sufficient numbers to meet the needs of residents. The policy also directs that if allegations or suspicions are made then interviews would be conducted with the accused person, residents, and all witnesses and that written statements should be obtained. The policy also directs that the facility will analyze the evidence and a determination would be made whether neglect occurred. The policy also directs	F 226	1. Address how corrective action will be accomplished for those residents found to have been affected by this deficient practice. 1a. Resident #2 successfully discharged home on 9/5/2015. No additional corrective action which can be rendered to Resident #2. 1b. Submission of a 24 hour report and 5 day investigation follow-up accordance with our existing policy for neglect of resident #2 to the state agency. 1c. Facility interviewed staff/residents that where present the evening of 8/28/15 in front of 200 hall. Facility Administration staff analyzed the findings and submit on the 5 day follow-up our determination. No apparent negative outcomes where noted. 2. Address how corrective action will be accomplished for those residents having potential to be affected by this deficient practice. 2a. Other residents residing on the same hall/section as Resident #2 on 8/28/15 (7pm-7am) will be considered as having the potential to have been affected by this deficient practice. 2b. The medical records of these	10/20/15

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

Electronically Signed | 10/09/2015

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F 226	Continued From page 1 that the facility will report the results of the investigation to the appropriate licensing agencies within designated timeframes. Nurse # 2 was interviewed on 9/23/15 at 2:15 PM regarding the occurrences of a shift which began on 8/28/15 at 7 PM. Nurse # 2 stated when the nurses reported to work they only had three nurses for the facility. Nurse # 2 stated that there was a discussion about resident assignments between Nurse # 3, Nurse # 5, and her. Nurse # 2 stated by 8:30 PM she had not started her medication pass and needed to do so. Nurse # 2 stated that Nurse # 5 stated she had not taken anything off of the medication cart and she was leaving. Nurse # 2 stated Nurse # 5 counted medication cart narcotics and left the building and that she never returned for the rest of her shift to care for residents. Nurse # 2 stated that she had been concerned that some of the residents had not received all of their scheduled medications and had reported this to Nurse # 17 at the beginning of the shift which began at 7 AM on 8/29/15, and the nurse had told her not to worry about it. Nurse # 2 stated that the administrator had talked to her about the occurrences of that night but she had never been asked to write a statement. Review of a formal grievance filed by Resident # 2 ' s family revealed that the family had complained to the facility that the resident had not received his medications because there was no nurse on the hall during the shift the nurse walked out of the facility. Specifically, review of a " Resident/Family Concern Form " filed by Resident # 2 ' s family on 8/31/15 revealed the statements, " Resident received no medicine or insulin on 8-28-15 from 7 PM until after 7 AM on 8-29-15- No nurse was on the hall during these hours. " Review of this form revealed an area	F 226	residents will be reviewed for medication omissions on 8/28/15 (7pm-7am). Any identified omissions will be communicated to the residents' attending physician. 2c. Grievances for past 14 days will be reviewed to ensure that there are were no concerns which would generate the use of our abuse policy/procedure. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. 3a. On 9/23/15, the Regional VP of Operations provided written guidance to facility Administrator that grievances or incorrect occurrences are to be thoroughly investigated to determine root cause and to determine if there were negative outcomes which must be addressed. 3b. Re-education on Facility Policies relating to grievance process and abuse policy and procedure to department heads conducted by Corporate Licensed Social Worker - 10/09/15. 3c. Re-education to facility staff on the grievance process/policy and the abuse policy/procedure conducted by Administrator and designee. Will be provided at time of orientation for new employees. 3d. Grievance/potential policy violations/allegations of abuse or neglect will be reported to Administrator or DON. Administrator and/or DON will initiate investigation of incident and if appropriate report to other agencies in compliance with established policy. 4. Indicate how the facility plans to monitor its performance to make sure that	

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F 226	Continued From page 2 entitled " Distributed to " and below this notation there was a list of different administrative staff members such as the nursing home administrator, the Director of Nursing, the Social Worker, and other administrative staff members which were listed below the notation to delineate to whom the concern had been distributed. On Resident # 2 ' s " Resident/Family Concern Form " the Rehab Director was circled as the administrative staff member to whom the concern was " distributed to. " The form also contained an area entitled, " Specific action taken. " On resident #2 ' s " Resident/Family Concern Form " the following notations were written in this area. " Nurse left facility unexpectantly & facility NS (nurse) did not pass rest meds for floor. Spoke to Mr.& Mrs. ... .regarding incident. They both were understanding, but they just want us to know. At this time, they voiced no further c/o (complaints of care). " There was no further documented follow up on the form. Under the area on the form entitled, " Person taking action " the form was blank. The form contained an area for the administrator or assistant nursing home administrator to sign. On Resident # 2 ' s form the administrator had signed the form but there was no date by the signature. Review of Resident # 2 ' s closed record revealed the resident resided at the facility from 5/22/15 until he was discharged home on 9/5/15. The resident had multiple medical diagnoses which included Diabetes, Chronic Kidney Disease, Hypertension, Atrial Fibrillation, and Muscle Weakness. Additionally the record included documentation that the resident had undergone surgical debridement on 7/17/15 for a chronic left lower extremity wound with Necrotizing Fasciits, and as of the date of 8/28/15 the resident was continuing to receive daily Vancomycin	F 226	solutions are sustained. 4a. Grievances will be reviewed 5 times a week for timely and completion of investigation for any potential concerns which could generate the use of the abuse policy/procedure. 4b. The grievance log will be reviewed 5 times a week by administrator and/or designee for completion and accuracy for 12 weeks. 4c. The grievance log will be reviewed 1 time a week by Regional Director of Clinical Services to ensure the timeliness and investigation are complete and to review for potential risk for utilization of the abuse policy/procedure. 5. Results of the audits will be taken to QA and A meeting monthly for 3 months.	

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F 226	Continued From page 3	F 226		

intravenously secondary to this medical diagnosis. Additionally the resident was ordered to receive multiple other medications.
Review of the resident ' s August MAR (medication administration record) revealed no nurses ' initials signifying that the resident received the following medications during the shift which began on 7 PM on 8/28/15 and ended at 7 AM on 8/29/15: Coumadin 6 mg (milligrams) which was due at 8 PM on the 28th; Atorvastatin Calcium Tablet 40 mg which was due at 9 PM on the 28th ; 21 units of Lantus SoloStar Solution Pen-Injector 100 units/ml due at 8 PM on the 28th; Omeprazole Capsule Delayed Release 1 capsule which was due at 6 AM on the 29th; Senna Lax tablet which was due at 8 PM on the 28th; Trazodone 50 mg tablet which was due at 8 PM on the 28th; Colace Capsule 100 mg which was due at 9 PM on the 28th; Metoprolol Tartrate 25 mg tablet which was due at 10 PM on the 28th and again at 6 AM on the 29th for Hypertension. Additionally the resident was scheduled to have a blood sugar reading check at 8 PM on the 28th and 6 AM on the 29th with a sliding scale coverage of Insulin administered. Neither of these times was it documented as done on the electronic MAR. (Past blood sugar readings had been as high as 400; specifically on the date of 8/24/15). Also on the MAR the resident was scheduled to have a pain assessment during the shift which was not documented as done on the 7P-7A shift MAR. (The previous day the resident was documented with a pain score of " 4 " and " 2. ") Also according to the MAR the resident was scheduled to have his intravenous access flushed with Heparin and Saline during the shift with no documentation on the MAR that it was done.
On 9/22/15 the facility provided the time card report of the nurse who had left the building on

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the evening of 8/28/15; according to the time card report Nurse # 5 clocked in at 7:17 PM and clocked out at 8:37 PM; indicating she was there for an hour and ten minutes.
Nurse # 1 was interviewed on 9/22/15 at 11 AM. Nurse # 1 stated he was the on call nurse for the week-end beginning on the evening of 8/28/15 and continuing through 8/30/15. Nurse # 1 stated on the afternoon of 8/28/15 he took the phone used to " take call " as the designated RN on call. Nurse # 1 stated he was notified on the evening of 8/28/15 that Nurse # 5 had left the building.
The administrator, interim DON, and another corporate nurse consultant were interviewed on 9/22/15 at 12:30 PM. The corporate nurse consultant stated that she had been made aware on 8/31/15 that Nurse # 5 had left unexpectedly on 8/28/15. The nurse consultant stated she had spoken to Nurse # 5 and provided a written statement signed by her and Nurse # 5 on the date of 9/2/15. The entire statement was written by the consultant and there was no written response statement from Nurse # 5 about what had occurred. The beginning of the statement read, " Discussed leaving facility because of call ins-leaving 3 nurses on 7P-7A ... ... " The administrator stated he had no further written documentation regarding investigation into the occurrence other than Resident # 2 ' s " Family/Resident concern Form " and the statement from the corporate consultant noting they had talked to Nurse # 5. The administrator stated the other residents would have received their medications because if they had not done so they would have told him.
There was no documented evidence provided from the administrative staff members of written statements from any of the employees who

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F 226	Continued From page 5 worked or were scheduled to be accountable for nursing coverage for the 8/28/15 shift beginning at 7 PM and a documented analysis of whether Nurse # 5 had abandoned her assignment after the hour and ten minutes she was in the facility. There was also no documented analysis if any of the RN managers had been negligent in their response to the staffing situation. Also there was no documentation that the facility investigated whether residents had been neglected or failed to receive care and services as a result of Nurse # 5 leaving the building and how residents had been reassigned or that a 24 hour and five day report had been filed to the state certification agency.	F 226		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to follow a physician ' s order for giving medications for 2 of 3 sampled residents reviewed for medication review (Resident ' s 8, and 9). Findings included: 1. Resident #8 was admitted to the facility on 09/21/15 at 1:35 PM with cumulative diagnoses including: cerebrovascular disease, atrial fibrillation, hypertension (HTN), asphasia, esophageal reflux, and urinary tract infection (UTI).	F 281	1. Address how corrective Action will be accomplished for those residents found to have been affected by this deficient practice. 1a. Resident #8 and #9; attending Physician notified of missed medications. No apparent negative outcomes related to missed medication. 2. Address how corrective action will be accomplished for those residents having potential to be affected by this deficient practice. 2a. All residents have the potential to be affected by this deficient practice. 3. Address what measures will be put into	10/20/15

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F 281	Continued From page 6 Review of Resident #8 ' s medical record revealed Physician orders for Hydralazine (an antihypertensive medication), and Cefdinir (an antibiotic). On 09/21/15 her admission orders specified she was to receive Hydralazine (an antihypertensive medication) and Cefdinir (an antibiotic) twice daily, and for both medications to start 09/21/15. On 09/21/15 at 11:35 PM the Pharmacist was interviewed and revealed that it was her expectation that ordered medications or re-ordered medication be received within 4 hours from their pharmacy provider. She said medication re-orders were done on the medication carts, and if a medication was needed sooner or was not available in the building, the nurse would be responsible to call the facility ' s 24 hour pharmacy line to have the medication order expedited through their back-up pharmacy. During interview with the Director of Nursing (DON) on 09/22/15 at 3:37 PM, the DON indicated that it is his expectation that medications be given as ordered by the physician. The DON then reviewed Resident #8 ' s MAR and confirmed the resident did not receive Hydralazine or Cefdinir the evening of 09/21/15. Interview with Nurse #11 on 09/22/15 at 3:46 PM revealed in the facility ' s Electronic Medication Administration Record (EMAR) two of Resident #8 ' s evening medications (Cefdinir 300 mg listed to be given at 8:00 PM and Hydralazine 25 mg listed to be given at 10:00 PM) were not signed off or given per MD order. Nurse #11 stated it was Resident #8 ' s nurse (Nurse #2 ' s) responsibility on 08/21/15 to make sure Resident #8 ' s	F 281	place or systemic changes made to ensure that deficient practice will not occur. 3a. Per guidance, "Directed in-service for medication administration and directed in-service reconciliation of controlled substance" will be conducted for licensed nurses. Training will be conducted by Leslie Lilas, licensed pharmacist with Cape Fear Long Term Pharmacy. 3b. Recorded training will be utilized for education with newly employed licensed nurses. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. DON and/or designee will audit missed medication report from PCC (electronic medical record) 5 times a week for 12 weeks. Any omissions will be investigated and reported to attending physician. 4b. Regional Director of Clinical Services will audit missed medication report 1 time a week for 12 weeks to ensure compliance. 4c. Omissions/errors will be reported to Administrator with disciplinary action as indicated. 5. Audits will be taken to QA and A monthly for 3 months for review and revisions as necessary.	

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F 281	Continued From page 7 medications were ordered, received, and given on time per MD order. Interview with Nurse # 2 on 9/23/15 at 2:15 PM revealed she had been assigned to care for Resident # 8 upon the date of the resident ' s 9/21/15 readmission. Nurse # 2 stated Resident # 8 arrived at the facility shortly after lunch and that the resident ate lunch at the facility. Nurse # 2 stated 9/21/15 was the first time she had been assigned a newly admitted resident for whom to care. Nurse # 2 stated she was assigned the resident until 7 PM and continued to care for Resident # 8 also from 7 PM until 11 PM when a nurse was needed to continue to cover that assignment. Nurse # 2 stated she was very busy that evening administering medications and she had a resident not doing well. Nurse # 2 stated another nurse in the building had received Resident # 8 ' s medications from the pharmacy courier at 9:30 PM and she had not known that they were in the building and had not administered medications to Resident # 8 while the resident was under her assignment. 2. Resident #9 was admitted to the facility on 05/4/15 with cumulative diagnoses including: gastrointestinal hemorrhage, urinary tract infection (UTI), end stage renal disease, peripheral vascular disease, dementia, hypertension (HTN). Review of Resident #9 ' s medical record revealed a Physician order for Renvela (a medication that binds Phosphate). On 07/14/15 her orders specified she was to receive Renvela (a Phosphate Binder) with meals, and for the medication to start 07/14/15 at 11:00 AM. (Renvela 800 mg x 2 tabs to be given with meals	F 281		

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F 281	Continued From page 8 8:00 AM, 12:00 PM, and 5:00 PM) Nurse #14 was interviewed on 09/22/15 at 8:00 AM. Nurse #14 stated Renvela was not available in the building at the time and should have been re-ordered by the previous nurse on the cart. Nurse #14 had to order Renvela electronically via their electronic EMAR. Nurse #14 stated Renvela was not available on the cart or in their Emergency Medication Kit (EMK). Nurse #14 re-ordered the medication Renvela to be delivered by their back-up pharmacy, which arrived at the facility at 11:55 AM. The DON verified that Renvela arrived by courier at 11:55 AM, and the DON confirmed that Resident #9 had missed her 8:00 AM dose, and would be given to Resident #9 with lunch. Nurse #14 was interviewed on 09/22/15 at 8:30 AM. Nurse #14 stated she did not give Renvela to Resident #9 because the previous nurse did not reorder the medication. Nurse #14 stated it was her expectation that all nurses should re-order medications when they run low on a medication, and that the previous nurse failed to reorder resident #9 ' s Renvela medication. On 09/21/15 at 11:35 PM the Pharmacist was interviewed and revealed that it was her expectation that ordered medications or re-ordered medication be received within 4 hours from their pharmacy provider. She said medication re-orders were done on the medication carts, and if a medication was needed sooner or was not available in the building, the nurse would be responsible to call the facility ' s 24 hour pharmacy line to have the medication order expedited through their back-up pharmacy.	F 281		

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F 333	Continued From page 9	F 333		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure it was free of significant medication errors in relation to a drug for which blood levels are drawn for one (Resident # 2) out of three sampled residents reviewed for pharmaceutical services. The findings included: Review of Resident # 2 ' s closed record revealed the resident resided at the facility from 5/22/15 until he was discharged home on 9/5/15. The resident had multiple medical diagnoses which included Diabetes, Chronic Kidney Disease, Hypertension, Atrial Fibrillation, and Muscle Weakness. Additionally the record included documentation that the resident had been hospitalized from 7/17/15 until 7/23/15. The resident ' s 7/23/15 hospital discharge summary noted that the resident had undergone surgical debridement on 7/17/15 for a chronic left lower extremity wound with Necrotizing Fasciitis. The resident ' s hospital discharge summary noted that the resident ' s wound cultures while he was hospitalized grew gram negative rods and gram positive cocci and that the resident ' s antibiotic of Vancomycin should be continued for 14 days post discharge. According to the 7/23/15 hospital discharge instructions the resident was ordered to receive Vancomycin 1,000 mg (milligrams) via intravenous (IV) route on a daily basis. Also under the discharge summary instructions it was noted	F 333	1. Address how corrective action will be accomplished for those residents found to have been affected by this deficient practice. 1a. Resident #2 no longer resides in facility. 2. Address how corrective action will be accomplished for those residents having potential to be affected by this deficient practice. 2a. Current residents admitted to facility in past 30 days will be reviewed for delay in medication administration. 2b. Attending physicians will be notified of any resident found during this review with a delay in medication administration. 2c. Residents admitted by facility have the potential to be affected by this deficient practice. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. 3a. Per guidance, "Directed in-service for medication administration and directed in-service reconciliation of controlled substance" will be conducted for licensed nurses. Training will be conducted by Leslie Lilas, licensed pharmacist with Cape Fear Long Term Pharmacy.	10/20/15

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F 333	Continued From page 10 that the facility should monitor the resident ' s Vancomycin blood levels. Review of transport records revealed that the resident left the hospital at 1:43 PM and arrived at the facility at 2:44 PM on his facility readmission date of 7/23/15. The hospital MAR (Medication Administration Record), located on the resident ' s facility medical record, revealed the times the resident had been scheduled to receive the Vancomycin for his Necrotizing Wound while hospitalized and the time it would next be due. According to the hospital MAR the resident had been started on the daily IV Vancomycin on 7/21/15 and his doses were on a 6 PM daily administration time. Also according to the hospital MAR the daily scheduled 6 PM dose of Vancomycin was still due to be administered on the afternoon the resident returned to the facility on 7/23/15. Review of the resident ' s electronic record under " progress notes-view all " for the dates of 7/23/15 and 7/24/15 revealed the first dose of Vancomycin following the resident ' s readmission was on the day after he was readmitted to the facility. The administration time was documented as 7:43 AM on 7/24/15. Further review of the " progress notes-view all " revealed a nurse documented on 7/24/15 at 10:40 AM, " ..I am putting in residents wound orders, they were not done or put in yesterday .... " Interview with the interim DON (Director of Nursing) on 9/22/15 at 4 PM and on 9/23/15 at 8:45 AM revealed that she had not been the DON at the time of the resident ' s readmission and she did not know why all the resident ' s orders had	F 333	3b. Recorded training will be utilized for education with newly employed licensed nurses. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. DON and/or designee will review new admissions daily for medication availability. 4b. Admissions will be reviewed 1 time a week for 12 weeks by Regional Director of Clinical Services to ensure medication availability. 4c. Failure to follow process would result in disciplinary action. 5. Results of audit to QA and A monthly times 3 months for review and revision as necessary.	

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F 333	Continued From page 11 not been placed in the computer system. Interview with the interim DON at this time revealed she had reviewed the resident ' s record and determined that the first dose of Vancomycin prescribed to treat the resident ' s Necrotizing Fasciitis wound was documented on the day after his readmission; 7/24/15 at 7:43 AM. The DON stated that the lack of documentation prior to that date and time would indicate that it would not have been given. A pharmacist who is involved in the delivery of medications to the facility was interviewed on 9/21/15 at 11:30 AM and stated that the facility can be provided with residents ' medications 24 hours per day. The pharmacist said that generally the medications can be delivered within four hours form the primary pharmacy and if a medication is needed sooner, the facility can use the backup pharmacy which generally can provide a medication within 2 to 2.5 hours after request. Also the pharmacist stated that the facility is provided with numerous back up medications in their emergency kit. Review of the list of back up medications supplied in the emergency kit revealed quantity of " 6 " under " Vancomycin 1 GM (gram) inj (injection). " Shortly after initiating the survey on 9/20/15, random drugs had been checked at 12:15 AM on 9/21/15 with the interim DON to determine the availability of back up medications which were noted on the list accompanying the facility ' s emergency medication kit located on the 300 hall medication room. All of the random medications chosen from the list to be checked had been found to be in the kit and available on 9/21/15 at 12:15 AM.	F 333		
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		10/20/15

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F 425 SS=D	Continued From page 12 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to assure documentation of shift to shift accountability of controlled drugs on two of two facility halls when a documented audit had revealed prior problems on both halls. The findings included: Interview with a pharmacist on 9/21/15 at 11:30 AM who was involved with the delivery of facility medications from their primary pharmacy supplier revealed that the nurses should be signing when they reconcile narcotics and that a pharmacy technician performs audits every 60 days. The pharmacist supplied the last audit which was	F 425	1. Address how corrective action will be accomplished for those residents found to have been affected by this deficient practice. 1a. No residents affected by this deficient practice at time of survey. 2. Address how corrective action will be accomplished for those residents having potential to be affected by this deficient practice. 2a. Current residents have the potential to be affected by this deficient practice. 100% audit of current controlled	

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F 425	Continued From page 13 dated 7/22/15. Review of this " Controlled substances Documentation Audit " dated 7/22/15 by a pharmacy staff member revealed that the audit of all four facility medication carts had resulted in notations of problems identified in one or all of the following audited areas: 1) Whether the " Math is correct; " 2) Whether the " Doses documented as removed are also documented on MAR (medication administration record; and 3) " missing shift to shift count signatures. " On 9/21/15 at 12 AM Nurse # 7 was observed to have the keys to the 200 front hall medication cart. The nurse stated he was the 7 PM to 7 AM nurse assigned to this medication cart. A review of the narcotic control record sheet for the 200 front hall medication cart at this time revealed a place for the off-going nurse to sign with the on-coming nurse; a column for the nurse to document the number of sheets and the number of cards the two nurses had counted and reconciled together when they changed shifts, and a column for the nurses to note if the count had been correct or incorrect. On 9/21/15 at 12 AM another nurse ' s signature was observed written in the designated area where Nurse # 7 would have signed for his current shift. Nurse # 7 stated he had counted when he reported to work but that the other nurse signed in the wrong place where his signature should have been, and he had not signed in either place. There was no signature in the column where the off-going nurse at 7 PM on 9/20/15 was to have signed when he was replaced by Nurse # 7 at 7 PM. It was blank. Review of the Narcotic Control Record revealed that two other on-coming nurses had failed to sign since 9/19/15. Also since the date of 8/25/15 there were only 3 days on which notations had been made in the columns noting the number of sheets and cards which had been counted and	F 425	substance conducted. 3. Address what measures will be put into place or systemic changes made to ensure that deficient practice will not occur. 3a. Per guidance, "Directed in-service for medication administration and directed in-service reconciliation of controlled substance' will be conducted for licensed nurses. Training will be conducted by Leslie Lilas, licensed pharmacist with Cape Fear Long Term Pharmacy. 3b. Recorded training will be utilized for education with newly employed licensed nurses. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. DON and/or designee will audit the controlled substance record daily for 4 weeks, 5 times a week for 8 weeks for accuracy and completion. 4b. Controlled substance record will be audited 1 time a week for 12 weeks by Regional Director of Clinical Services for accuracy and completion. 4c. Disciplinary action as indicated for failure to comply with process. 5. Results of audits to QA and A monthly for 3 months for review and revisions as needed.	

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reconciled between the off-going and on-coming nurses. Since 8/25/15 there had never been a notation whether the count was correct or incorrect within the column designated for this. Nurse # 8 was observed to be administering medications from the 200 back hall medication cart on 9/20/15 at 9:50 PM. Review of the narcotic control record for this medication cart at the time revealed that Nurse # 8 had signed as either the on-coming nurse two times since 9/18/15 without the documentation of the off-going nurse signifying that narcotics had been counted and reconciled between two nurses. Nurse # 8 stated that she had counted but that the other nurse had not signed. Since the date of 8/26/15 there were only three days which had notations of how many sheets and narcotic cards had been reconciled between the off-going nurse and on-coming nurse. There was no notation if the count had been correct or incorrect on any day since 8/26/15.

Review of the 300 hall front narcotic record on 9/21/15 at 12:15 AM revealed multiple blanks since 8/10/15 for both the off-going and on-coming shift nurses who had reconciled narcotics. Only on five days had a notation been made regarding the number of cards and/or sheets reconciled since 8/10/15. There was never a notation whether the count had been correct or incorrect since 8/10/15 within the column designated for this notation. Review of the 300 Back hall medication cart narcotic control record since the date of 8/26/15 revealed multiple blanks for either the off-going or on-coming nurses ' signatures who would have signed when they reconciled the narcotics. There was no notation since 8/26/15 how many cards or sheets of narcotics the off-going nurse and on-coming nurses had reconciled. There was no notation

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whether the count had been correct or incorrect since 8/26/15 on the narcotic control record within the designated area.

Additionally Nurse # 9 and Nurse # 10 were observed to have the keys to these 300 medication carts on 9/21/15 at 12:15 AM. These two nurses stated that on their medication cart keys they both had a key to access the stock back up narcotic box located in the locked 300 medication room. The nurses stated it took both their keys to unlock the box. The nurses stated that neither of them had counted the narcotic stock medications with either of the 300 Hall off-going nurses before they accepted the keys. Nurse # 9 and Nurse # 10 stated they counted with each other as both on-coming nurses. They were unable to state what they would do to resolve any issues if they were to find narcotics missing when they counted together as both on-coming nurses and the off-going nurses had already left. Nurse # 9 stated that no one had taught them the expected procedures for counting the stock medications and reconciling them.

Review of the Narcotic Control Record for the back-up Narcotic Box revealed that since the first of September the back-up Narcotic box had been reconciled only three times between an off-going and an on-coming nurse.

Interview with the pharmacist on 9/21/15 at 11:30 AM revealed the facility owned the stock medications in the back up box and that it was her recommendation that the POA (power of attorney), whom she defined as being the person accountable in the facility for ordering the narcotics, would be the one who reconciled them. The pharmacist also stated that it would be her recommendation that the back-up narcotics would be reconciled on Mondays and Thursdays.

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F 425	Continued From page 16 The pharmacist stated this would allow for replenishment before and after week-ends.	F 425		