STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	C 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & RETIREMENT	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to treat a resident in a dignified manner resulting in feelings of embarrassment, frustration, and disrespect for 1 of 4 residents (Resident #6) reviewed for dignity. The findings included: Resident #6 was admitted to the facility on 2/26/16 with multiple diagnoses including respiratory failure, mastocytosis, chronic pain syndrome, anxiety, and depression. The admission MDS dated 3/3/16 indicated her cognition was intact and she required assistance with all activities of daily living with the exception of eating. She was indicated to have verbal behavioral symptoms directed toward others 1-3 days during the 7 day review period and other behavioral symptoms not directed toward others 1-3 days during the 7 day review period. The behaviors were indicated to have no impact on Resident #6 or others. She had no rejection of care noted. During an interview on 3/29/16 at 4:00 PM when Resident #6 was asked if staff treated her with respect and dignity, she stated the Director of Nursing (DON) sometimes embarrassed her and made her upset. She indicated the DON would say things like 'oh lord what's that Ms. [Resident #6] want now'. When asked if she was able to recall any specific examples with the DON,	F 241	1) Resident #6 was interviewed by Facility administrator on 3-15-16. The resident interview was documented on a resident concern form, to include resolution date of 3-15-16. The Director of Nursing received re-education regarding treating a resident with dignity and respect on 3-31-16 by facility administrator. 2) The facility residents identified as interviewable will be interviewed by the administrator or designee to ensure that no other resident has been affected by alleged deficient practice. 3) All facility staff including Therapy, Housekeeping and Dietary Departments will receive reeducation on treating each resident with dignity and respect. Re-education will include action to be taken if any staff member observes or has knowledge that any resident has expressed feeling embarrassed or made to feel sad. The re- education will be initiated on 4-18-16 and will be completed 4-27-16 by the Administrator or designee. Staff that are not re- educated prior to 4-27-16 will be scheduled for the education prior to working their next shift. The administrator or designee will conduct random interviews with interviewable residents and Family members of non interviewable residents. Five interviews will be conducted weekly for four weeks and monthly thereafter for five months.	4/27/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/18/2016

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F 241	Continued From page 1 Resident #6 stated she was unable to remember the exact date, but about a week ago she was in her room with the DON and Nurse Practitioner (NP). She stated she didn't remember exactly what they were discussing, but she was informing them about some concern she had. Resident #6 revealed the DON untucked his shirt and pulled the bottom of his shirt up to his neckline exposing his bare skin and stated something like 'let me show you what a real problem is, I was in Vietnam and had real problems'. She indicated she did not know how to respond to the DON. She stated she felt this was inappropriate and also felt as if he might have been making fun of her concerns. She revealed this was frustrating for her and made her feel like she was unable to express herself because she was not respected. She stated she had not shared these feelings with the DON or other staff. An interview was conducted with the NP on 3/29/16 at 5:37 PM. The NP confirmed the specific incident Resident #6 had shared involving herself and the DON had occurred. She stated she was unable to recall the exact date. She indicated she was in Resident #6's room with the DON. She stated Resident #6 was discussing some concerns. She was unable to recall the exact concerns, but indicated Resident #6 brought up something related to her stomach. The NP revealed the DON untucked his shirt and lifted it up to the area underneath his breast bone and stated something about the scars he had from being a veteran. She indicated his bare skin was exposed on his entire stomach. She stated the DON had his shirt lifted for only a second or two and then proceeded to tuck his shirt back in. The NP stated there was no medical reason for the DON to expose his bare stomach. She indicated she thought it was inappropriate. She	F 241	4) Audits will be presented to Quality Improvement Committee Monthly for review, by the Administrator for six months. The committee will make revisions to the plan as indicated.	

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F 241	Continued From page 2	F 241		

stated she had not discussed the incident afterwards with the DON and she had not shared it with the Administrator.
An interview was conducted with the DON on 3/30/16 at 3:45 PM. The DON indicated the specific incident Resident #6 had shared involving himself and the NP was inaccurate. He stated he recalled being in Resident #6's room when she was discussing something about her stomach or breast region. He indicated Resident #6 wanted to show him something under her breasts and she began to lift up her clothing. He stated he asked her not to do that. He indicated Resident #6 said something to the effect of 'you don't know what it feels like'. He stated he then shared with Resident #6 that he had been in Vietnam and understood pain. He indicated he was unable to recall if anyone else was in the room at that time. The DON reiterated that he denied lifting up his shirt to expose his bare stomach to Resident #6 and the NP. The DON also stated that Resident #6 had never informed him of feeling embarrassed or upset by anything he had said. He denied making any statements such as, 'oh lord what's that [Resident #6] want now'.
An interview was conducted with the Administrator on 3/30/16 at 4:00 PM. The Administrator indicated he was aware of the specific incident Resident #6 had shared involving the DON, but he was unaware the NP was also present during the incident. He stated he spoke to Resident #6 regarding the incident and she informed him the DON had lifted up his shirt and exposed his bare skin. He revealed Resident #6 had not shared with him any negative feelings such as embarrassment, frustration, or not feeling respected. He indicated Resident #6 stated that at no time had she felt

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F 241	Continued From page 3 unsafe at the facility. The Administrator stated he also spoke with the DON regarding the incident. He stated the DON denied lifting up his shirt to expose his bare skin to Resident #6. He indicated he had not spoken to the NP regarding the incident as he was unaware of her involvement. The Administrator reiterated the discrepancies in the statements of events as told by Resident #6 and the DON. He additionally reiterated that Resident #6 had not shared her negative feelings with him. The Administrator stated he had addressed the incident and felt it had been resolved.	F 241		
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 record reviews and staff interviews, the facility failed to obtain laboratory work as ordered by the physician for one of three residents (Resident #5) reviewed for labs. Resident # 5 was admitted to the facility on 3/8/16 with multiple diagnoses including a fracture of the right wrist, a fracture of the right foot, multiple sclerosis and hypertension. The Laboratory Management policy dated August 2012 stated requested lab work was to be documented in the Laboratory Request Log Book or designated record. A review of the Physician Orders revealed an	F 281	1) Resident # 5 no longer resides in the facility. 2) The Director of Nursing or Designee will complete an audit to ensure that residents' physician lab orders had been scheduled or obtained. The audit was initiated on 4-18-16 and completed on 4-25-16. 3). Director of Nursing or Designee will provide re-education to the facility licensed nurses, including weekend and PRN nurses regarding the facility procedure for scheduling labs. Licensed staff who do not receive the re-education prior to 4-27-16 will receive re-education prior to working their next shift. The Director of Nursing or designee will Conduct random resident lab audits to ensure that labs are scheduled and obtained per physician orders. Five residents will be audited weekly for four weeks and monthly thereafter for five months	4/27/16

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F 281	Continued From page 4 order dated 3/8/16 which read Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) in one week. A review of the resident ' s medical chart on 3/30/16 revealed no lab results for a CBC or a BMP. A review of the Laboratory Request Log Book revealed no documentation of the physician order dated 3/8/16 requesting a CBC and a BMP to be drawn for Resident #5. An interview with the Second Floor Unit Nurse Manager was conducted on 3/30/16 at 10:03 AM. She stated the physician order dated 3/8/16 requesting a CBC and a BMP to be drawn in one week for Resident #5 was not documented in the Laboratory Request Log Book. The Nurse Manager stated she expected the nursing staff to document all requests for laboratory work in the Laboratory Request Log Book. She stated the laboratory staff refer to the Laboratory Request Log Book to identify physician lab orders. She stated the CBC and the BMP were not obtained for Resident #5 as ordered by the physician. An interview with the Nurse Practitioner (NP) was conducted on 3/30/16 at 1:30 PM. The NP stated she expected the facility to obtain laboratory work as ordered by the physician. An interview with the Director of Nursing (DON) was conducted on 3/30/16 at 3:46 PM. The DON stated he expected the nursing staff to document physician orders for lab work in the Laboratory Request Log Book.	F 281	4. Findings of the audits will be reported to Quality Improvement Committee by the Director of Nursing for six months. The Committee will review the results and make revisions to the plan as indicated.	
F 333	483.25(m)(2) RESIDENTS FREE OF	F 333		4/27/16

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F 333 SS=D	Continued From page 5 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, resident interview, staff interview, and pharmacy staff interview, the facility failed to maintain a sufficient amount of antianxiety medication ordered by the physician resulting in the omission of the antianxiety medication for seven doses for one of three residents (Resident #7) reviewed for medications. The findings included: Resident #7 was admitted to the facility on 3/3/16 with multiple diagnoses including bipolar disorder. Her admission Minimum Data Set assessment dated 3/10/16 indicated her cognition was intact and she received antianxiety medications on seven out of seven days during the look back period. An interview was conducted on 3/30/16 at 8:30 AM with Resident #7. She revealed she had missed several doses of her Klonopin (antianxiety medication) since her admission because the facility reportedly didn't have the medication. She indicated staff told her the Klonopin had not arrived from the pharmacy. Resident #7 stated she didn't know why it took several days to receive a medication from the pharmacy. She indicated she spoke to the Second Floor (SF) Nurse Unit Manager (UM) about her concerns and she stated she was going to look into it. She stated she had not heard back from the SF Nurse UM.	F 333	1) Resident #7's attending physician was notified on 3-21-16 of the omission of Klonopin on the 3/19 thru 3-22-16 by Director of Nursing. The attending physician ordered to resume the Klonopin 0.5mg on 3-22-16. 2) A Facility audit will be completed of Residents' current Medication Administration Records to ensure that each medication is/was available and is/was administrated. 3) The Director of Nursing or designee will provide re-education to the licensed nurses on reordering medication and procedure to follow if medication is not available. The re-education will be initiated on April 18 and completed on April 27 and include all licensed nurses including PRN and weekend. Licensed staff who do not receive the re-education by 4/27 will be re-educated prior to the next shift worked. An audit will be conducted by the Director of Nursing or designee of five residents Medication Administration Records to ensure that medications are available and being administrated, Audits will be conducted weekly for four weeks and monthly for five months 4) Findings of the audits will be reported to Quality Improvement Committee by the Director of Nursing monthly for six months. The committee will review the results and determine further monitoring is indicated	

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F 333	Continued From page 6 The medical record was reviewed for Resident #7. A Physician's Order dated 3/4/16 indicated Klonopin 0.5 milligrams (mg) twice daily for Resident #7. The March 2016 Medication Administration Record (MAR) for Resident #7 was reviewed. The MAR included the order for Klonopin 0.5mg twice daily. Further review of the MAR revealed Resident #7 was not administered the second dose of Klonopin on 3/19 and was not administered either dose of Klonopin on 3/20, 3/21, or 3/22. The MAR also indicated the following notations: - 3/19/16, 3-11, Klonopin 0.5mg, pharmacy notified, [Nurse #1] - 3/20/16, 4p, Klonopin 0.5mg, pharmacy aware, [Nurse #1] - 3/21/16, 8:00A, Klonopin 0.5mg, on order from pharmacy, [Nurse #2] A Nursing Progress Note dated 3/21/16 indicated resident called for assistance stating she had discomfort in her chest. The Nurse Practitioner (NP) completed an assessment and wrote new orders. A Physician's Order with a time and date of 3/21/16 at 8:50 PM indicated Ativan (antianxiety medication) 0.5mg every four hours as needed for anxiety. An interview was conducted on 3/30/16 at 9:30 AM with the SF Nurse UM. She stated Resident #7 had informed her she had not been administered several doses of her Klonopin because the facility was out of it. The March 2016 MAR for Resident #7 was reviewed with the	F 333		

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F 333	Continued From page 7 SF Nurse UM. She stated if there was a circle around the letter on the MAR it indicated the medication was not administered. The MAR revealed Resident #7 was not administered the second dose of Klonopin on 3/19 and was not administered either dose of Klonopin on 3/20, 3/21, or 3/22. The SF Nurse UM stated she was unable to say why the facility had not obtained a new prescription from the physician prior to running out of the Klonopin. The procedure for obtaining a new prescription was reviewed with the SF Nurse UM. She stated that Klonopin was a controlled substance and required a new prescription from the physician each time the medication ran out. She indicated the prescription was to be requested from the physician by a nurse prior to the depletion of the medication. She stated this was a team effort. She indicated any nurse who had administered the Klonopin to Resident #7 had been aware of the amount of Klonopin remaining. The SF Nurse UM revealed no one requested a new prescription from the physician prior to running out of Klonopin for Resident #7. She additionally stated she was unable to say why a new prescription of Klonopin had not been received the same day it was noted to run out (3/19/16). An interview was conducted on 3/30/16 at 9:45 AM with the Director of Nursing (DON). The March 2016 MAR for Resident #7 was reviewed with the DON. He stated if there was a circle around the letter it indicated the medication was not administered. The MAR revealed Resident #7 was not administered the second dose of Klonopin on 3/19 and was not administered either dose of Klonopin on 3/20, 3/21, or 3/22. He indicated his expectation was for the new prescription of Klonopin to be requested from the	F 333		

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physician and ordered from the pharmacy prior to running out of the current supply of Klonopin. He stated his expectation was for no gaps in the administration of medication caused by the facility running out of the medication. He additionally stated he was unable to say for sure why a new prescription of Klonopin had not been received the same day it was noted to run out (3/19/16). He stated the nurse working on 3/19/16 had contacted the physician on-call, but a prescription was unable to be obtained.

An interview was conducted on 3/30/16 at 10:05 AM with Nurse #2. The March 2016 MAR for Resident #7 was reviewed with Nurse #2. Nurse #2 indicated she was working on the morning of 3/21/16. She stated the Klonopin for Resident #7 was not at the facility. She indicated it was on order at the pharmacy. She stated she was unable to say why a new prescription of Klonopin had not been received prior to running out of the medication. She additionally stated she was unable to say why a new prescription of Klonopin had not been received the same day it was noted to have run out. She indicated she had not worked on 3/19/16 or 3/20/16.

An interview was conducted on 3/30/16 at 10:30 AM with the NP. She stated she was made aware on 3/21/16 or 3/22/16 that Resident #7 had not been administered a few doses of Klonopin because the facility was out of it. She was unable to recall the exact date she was notified. She reviewed the medical record for Resident #7. The NP indicated she had written an order for Resident #7 for Ativan 0.5mg every 4 hours as needed for anxiety on the evening of 3/21/16. She explained that staff had reported to her that Resident #7 was complaining of chest pressure

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that appeared to be anxiety based. She indicated at that point in time she had not been notified of the omission of several doses of Klonopin for Resident #7. She stated she wrote the Ativan order without realizing Resident #7 was on Klonopin. She indicated if she had been informed prior to that time she would not have written the order for a medication in with the same classification. She also indicated the anxiety symptoms Resident #7 experienced on 3/21/16 possibly were related to her not receiving her antianxiety medication for several days, but she was unable to make any direct link between the two with certainty. The NP stated her expectation was for staff to notify her as soon as they realized a medication was omitted. She additionally stated her expectation was for staff to inform herself or the physician of the need for a new prescription prior to the depletion of their supply.
A phone interview was conducted on 3/30/16 at 10:45 AM with the facility ' s Pharmacy Staff #1. Pharmacy Staff #1 reviewed the prescription record for Resident #7. She revealed a prescription for Klonopin 0.5mg twice daily for Resident #7 was received on 3/22/16. She additionally indicated the Klonopin had been delivered to the facility on the same date.

A phone interview was conducted on 3/30/16 at 11:00 AM with Nurse #1. She indicated she recalled a few days recently that Resident #7 was not administered Klonopin as the facility was out of it. She stated she was working the 3:00 PM - 11:00 PM shift on 3/19/16 and noticed Resident #7 had no available Klonopin. She stated at some point during her shift she contacted the physician on-call and requested a prescription for Klonopin 0.5mg twice daily for Resident #7. She stated the physician on call informed her that he

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was unable to provide the prescription. Nurse #1 indicated she had not known why he was unable to provide a prescription. She stated she had not contacted Resident #7's attending physician and had not notified the DON that she was unable to obtain a prescription. She indicated she was also working the 3:00 PM - 11:00 PM shift on 3/20/16 and Resident #7 continued to have no Klonopin. Nurse #1 indicated it was not normal to run out of medication. She stated the normal procedure for obtaining a prescription was to write it in a binder the facility maintains for the doctors. She indicated this should've been done prior to running out of a medication so there was no lapse in the administration of the medication. She stated this could ' ve been done by any nurse that noticed the amount of medication was running low. Nurse #1 revealed that in this instance, no one completed that task.

An interview was conducted with the Administrator on 3/30/16 at 11:50 AM. He provided a facility Medication Variance Report (MVR) for the omission of Klonopin for Resident #7. The MVR indicated the omission of Klonopin 0.5mg twice daily from 3/19/16 through 3/22/16 for Resident #7. It indicated the cause of the error was that a hard script was required for dispensing and none were available until the next business day with follow up on Monday. The form indicated notifications had been made to the Supervisor/DON, Physician, and Pharmacy on 3/19/16 by Nurse #1. He stated they were aware of the error. The Administrator was unable to explain why the physician on-call was unable to provide a prescription for Klonopin 0.5mg twice daily for Resident #7 resulting in a continued the delay with the administration of the medication and the omission of multiple additional doses.

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F 333	Continued From page 11 A second interview was conducted with the DON on 3/30/16 at 11:52 AM. He indicated he had reviewed the MVR and was also aware of the error. He indicated he had talked to staff about the error, but he had not had a formal inservice with staff to address the concern. A phone interview was conducted on 3/30/16 at 1:30 PM with the physician on-call from 3/19/16 through 3/20/16. He indicated he was a Physician's Assistant (PA) and confirmed he was the physician on-call the weekend of 3/19/16 and 3/20/16. He stated that was his first weekend in the on call rotation. He indicated he remembered the facility contacting him, but he was unable to recall a specific request for a prescription for Klonopin for Resident #7. He stated if they had asked him he would've told them he wasn't able to write a prescription for it. He indicated he was still awaiting approval from Medicaid (MA) and until that time he was unable to write prescriptions for any controlled medications. The PA indicated he should've notified his supervisor for assistance with this prescription. He stated he had not made that notification. A phone interview was conducted on 3/30/16 at 1:45 PM with Resident #7's attending physician. The physician was the supervisor of the facility ' s on-call physician services. He indicated the PA who provided physician on-call services on the weekend of 3/19/16 and 3/20/16 had just began working with the on-call rotation. He stated he was aware the PA was awaiting approval from MA to write prescriptions for controlled medications. He indicated the expectation was for the PA to contact him to write the prescription. He stated that did not occur. The physician indicated he	F 333		

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F 333	Continued From page 12 was informed of the need for the Klonopin prescription for Resident #7 on 3/21/16. He stated the Klonopin 0.5mg twice daily prescription for Resident #7 was written on 3/21/16 or 3/22/16. He indicated he was unsure of the date. The physician additionally indicated the facility was unaware the PA was unable to write prescriptions for controlled medications. A follow up interview was conducted on 3/30/16 at 3:00 PM with the DON. He stated he was not aware until this date that the physician on-call on 3/19/16 and 3/20/16 was not able to write prescriptions for controlled medications. He indicated he expected the physician on-call to notify his supervisor to obtain a prescription and he expected the nurse to contact the resident's physician and/or himself to address the need.	F 333		
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and pharmacy staff interview, the facility failed to maintain physician services to	F 385	1) Resident #7's attending physician was notified on 3-21-16 by the Director of Nursing of the omission of Klonopin on 3/19 thru 3-22-16. The attending physician ordered to resume the Klonopin 0.5mg on 3-22-16 2) A Facility audit will be completed of residents current Medication Administration Record to ensure that each medication is available and being administrated. The audit will begin on 4-18-16 and completed by 4-27-16 by the Director of Nursing or designee.	4/27/16

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F 385	Continued From page 13 meet the needs of a resident who required a prescription for an antianxiety medication resulting in delayed obtainment of the medication and the omission of the medication for seven doses for 1 of 3 residents (Resident #7). The findings included: Resident #7 was admitted to the facility on 3/3/16 with multiple diagnoses including bipolar disorder. Her admission Minimum Data Set assessment dated 3/10/16 indicated her cognition was intact and she received antianxiety medications on seven out of seven days during the look back period. An interview was conducted on 3/30/16 at 8:30 AM with Resident #7. She revealed she had missed several doses of her Klonopin (antianxiety medication) since her admission because the facility reportedly didn't have the medication. She indicated staff told her the Klonopin had not arrived from the pharmacy. Resident #7 stated she didn't know why it took several days to receive a medication from the pharmacy. She indicated she spoke to the Second Floor (SF) Nurse Unit Manager (UM) about her concerns and she stated she was going to look into it. She stated she had not heard back from the SF Nurse UM. The medical record was reviewed for Resident #7. A Physician's Order dated 3/4/16 indicated Klonopin 0.5 milligrams (mg) twice daily for Resident #7. The March 2016 Medication Administration Record (MAR) for Resident #7 was reviewed. The MAR included the order for Klonopin 0.5mg twice daily. Further review of the MAR revealed	F 385	3) An audit will be conducted by the Director of Nursing or designee of five random residents Medication Administration Records to ensure that medications are available and being administrated. The audits will be conducted weekly times four and then monthly for five months.The Director of Nursing will educate The Medical Director on proper Physician coverage to meet the medical care of our residents on 4-1-16. The Director of Nursing or designee will also educate all licensed Nurses, to include weekend and PRN staff on process to follow if medication is unavailable. Education will start on 4-18 and be completed on 4-27-16. Facility licensed staff that does not receive the re-education will be scheduled for the education prior to working their next shift. 4) Findings of the audits will be reported to the Quality Improvement Committee monthly for six months by the Director of Nursing. The committee will review the results and revise the plan as indicated	

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F 385	Continued From page 14 Resident #7 was not administered the second dose of Klonopin on 3/19 and was not administered either dose of Klonopin on 3/20, 3/21, or 3/22. The MAR also indicated the following notations: - 3/19/16, 3-11, Klonopin 0.5mg, pharmacy notified, [Nurse #1] - 3/20/16, 4p, Klonopin 0.5mg, pharmacy aware, [Nurse #1] - 3/21/16, 8:00A, Klonopin 0.5mg, on order from pharmacy, [Nurse #2] A Nursing Progress Note dated 3/21/16 indicated resident called for assistance stating she had discomfort in her chest. The Nurse Practitioner (NP) completed an assessment and wrote new orders. A Physician's Order with a time and date of 3/21/16 at 8:50 PM indicated Ativan (antianxiety medication) 0.5mg every four hours as needed for anxiety. An interview was conducted on 3/30/16 at 9:30 AM with the SF Nurse UM. She stated Resident #7 had informed her she had not been administered several doses of her Klonopin because the facility was out of it. The March 2016 MAR for Resident #7 was reviewed with the SF Nurse UM. She stated if there was a circle around the letter on the MAR it indicated the medication was not administered. The MAR revealed Resident #7 was not administered the second dose of Klonopin on 3/19 and was not administered either dose of Klonopin on 3/20, 3/21, or 3/22. The SF Nurse UM stated she was unable to say why the facility had not obtained a new prescription from the physician prior to running out of the Klonopin. The procedure for	F 385		

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obtaining a new prescription was reviewed with the SF Nurse UM. She stated that Klonopin was a controlled substance and required a new prescription from the physician each time the medication ran out. She indicated the prescription was to be requested from the physician by a nurse prior to the depletion of the medication. She stated this was a team effort. She indicated any nurse who had administered the Klonopin to Resident #7 had been aware of the amount of Klonopin remaining. The SF Nurse UM revealed no one requested a new prescription from the physician prior to running out of Klonopin for Resident #7. She additionally stated she was unable to say why a new prescription of Klonopin had not been received the same day it was noted to run out (3/19/16).

An interview was conducted on 3/30/16 at 9:45 AM with the Director of Nursing (DON). The March 2016 MAR for Resident #7 was reviewed with the DON. He stated if there was a circle around the letter it indicated the medication was not administered. The MAR revealed Resident #7 was not administered the second dose of Klonopin on 3/19 and was not administered either dose of Klonopin on 3/20, 3/21, or 3/22. He indicated his expectation was for the new prescription of Klonopin to be requested from the physician and ordered from the pharmacy prior to running out of the current supply of Klonopin. He stated his expectation was for no gaps in the administration of medication caused by the facility running out of the medication. He additionally stated he was unable to say for sure why a new prescription of Klonopin had not been received the same day it was noted to run out (3/19/16). He stated the nurse working on 3/19/16 had contacted the physician on-call, but a prescription

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F 385	Continued From page 16 was unable to be obtained. An interview was conducted on 3/30/16 at 10:05 AM with Nurse #2. The March 2016 MAR for Resident #7 was reviewed with Nurse #2. Nurse #2 indicated she was working on the morning of 3/21/16. She stated the Klonopin for Resident #7 was not at the facility. She indicated it was on order at the pharmacy. She stated she was unable to say why a new prescription of Klonopin had not been received prior to running out of the medication. She additionally stated she was unable to say why a new prescription of Klonopin had not been received the same day it was noted to have run out. She indicated she had not worked on 3/19/16 or 3/20/16. An interview was conducted on 3/30/16 at 10:30 AM with the NP. She stated she was made aware on 3/21/16 or 3/22/16 that Resident #7 had not been administered a few doses of Klonopin because the facility was out of it. She was unable to recall the exact date she was notified. She reviewed the medical record for Resident #7. The NP indicated she had written an order for Resident #7 for Ativan 0.5mg every 4 hours as needed for anxiety on the evening of 3/21/16. She explained that staff had reported to her that Resident #7 was complaining of chest pressure that appeared to be anxiety based. She indicated at that point in time she had not been notified of the omission of several doses of Klonopin for Resident #7. She stated she wrote the Ativan order without realizing Resident #7 was on Klonopin. She indicated if she had been informed prior to that time she would not have written the order for a medication in with the same classification. She also indicated the anxiety symptoms Resident #7 experienced on 3/21/16	F 385		

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F 385	Continued From page 17 possibly were related to her not receiving her antianxiety medication for several days, but she was unable to make any direct link between the two with certainty. The NP stated her expectation was for staff to notify her as soon as they realized a medication was omitted. She additionally stated her expectation was for staff to inform herself or the physician of the need for a new prescription prior to the depletion of their supply. A phone interview was conducted on 3/30/16 at 10:45 AM with the facility's Pharmacy Staff #1. Pharmacy Staff #1 reviewed the prescription record for Resident #7. She revealed a prescription for Klonopin 0.5mg twice daily for Resident #7 was received on 3/22/16. She additionally indicated the Klonopin had been delivered to the facility on the same date. A phone interview was conducted on 3/30/16 at 11:00 AM with Nurse #1. She indicated she recalled a few days recently that Resident #7 was not administered Klonopin as the facility was out of it. She stated she was working the 3:00 PM - 11:00 PM shift on 3/19/16 and noticed Resident #7 had no available Klonopin. She stated at some point during her shift she contacted the physician on-call and requested a prescription for Klonopin 0.5mg twice daily for Resident #7. She stated the physician on call informed her that he was unable to provide the prescription. Nurse #1 indicated she had not known why he was unable to provide a prescription. She stated she had not contacted Resident #7's attending physician and had not notified the DON that she was unable to obtain a prescription. She indicated she was also working the 3:00 PM - 11:00 PM shift on 3/20/16 and Resident #7 continued to have no Klonopin. Nurse #1 indicated it was not normal to run out of medication. She stated the normal	F 385		

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procedure for obtaining a prescription was to write it in a binder the facility maintains for the doctors. She indicated this should've been done prior to running out of a medication so there was no lapse in the administration of the medication. She stated this could've been done by any nurse that noticed the amount of medication was running low. Nurse #1 revealed that in this instance, no one completed that task.

An interview was conducted with the Administrator on 3/30/16 at 11:50 AM. He provided a facility Medication Variance Report (MVR) for the omission of Klonopin for Resident #7. The MVR indicated the omission of Klonopin 0.5mg twice daily from 3/19/16 through 3/22/16 for Resident #7. It indicated the cause of the error was that a hard script was required for dispensing and none were available until the next business day with follow up on Monday. The form indicated notifications had been made to the Supervisor/DON, Physician, and Pharmacy on 3/19/16 by Nurse #1. He stated they were aware of the error. The Administrator was unable to explain why the physician on-call was unable to provide a prescription for Klonopin 0.5mg twice daily for Resident #7 resulting in a continued the delay with the administration of the medication and the omission of multiple additional doses.

A second interview was conducted with the DON on 3/30/16 at 11:52 AM. He indicated he had reviewed the MVR and was also aware of the error. He indicated he had talked to staff about the error, but he had not had a formal inservice with staff to address the concern.

A phone interview was conducted on 3/30/16 at 1:30 PM with the physician on-call from 3/19/16

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through 3/20/16. He indicated he was a Physician's Assistant (PA) and confirmed he was the physician on-call the weekend of 3/19/16 and 3/20/16. He stated that was his first weekend in the on call rotation. He indicated he remembered the facility contacting him, but he was unable to recall a specific request for a prescription for Klonopin for Resident #7. He stated if they had asked him he would ' ve told them he wasn't able to write a prescription for it. He indicated he was still awaiting approval from Medicaid (MA) and until that time he was unable to write prescriptions for any controlled medications. The PA indicated he should've notified his supervisor for assistance with this prescription. He stated he had not made that notification.

A phone interview was conducted on 3/30/16 at 1:45 PM with Resident #7's attending physician. The physician was the supervisor of the facility's on-call physician services. He indicated the PA who provided physician on-call services on the weekend of 3/19/16 and 3/20/16 had just began working with the on-call rotation. He stated he was aware the PA was awaiting approval from MA to write prescriptions for controlled medications. He indicated the expectation was for the PA to contact him to write the prescription. He stated that did not occur. The physician indicated he was informed of the need for the Klonopin prescription for Resident #7 on 3/21/16. He stated the Klonopin 0.5mg twice daily prescription for Resident #7 was written on 3/21/16 or 3/22/16. He indicated he was unsure of the date. The physician additionally indicated the facility was unaware the PA was unable to write prescriptions for controlled medications.

A follow up interview was conducted on 3/30/16 at

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F 385	Continued From page 20 3:00 PM with the DON. He stated he was not aware until this date that the physician on-call on 3/19/16 and 3/20/16 was not able to write prescriptions for controlled medications. He indicated he expected the physician on-call to notify his supervisor to obtain a prescription and he expected the nurse to contact the resident's physician and/or himself to address the need.	F 385		