

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345044</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/19/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST JOSEPH OF THE PINES HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 GOSSMAN DRIVE</b> <b>PINEHURST, NC 28374</b>		
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F 000	INITIAL COMMENTS  The surveyor entered the facility on 10/15/18 to conduct a complaint survey and exited on 10/17/18. Additional information was obtained on 10/19/18. Therefore, the exit date was changed to 10/19/18.	F 000			
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)  §483.12(b) The facility must develop and implement written policies and procedures that:  §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and  §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to investigate the suspected misappropriation of residents' narcotic medications by one nurse (Nurse # 1). Three nurses had reported to an administrative staff member discrepancies in documented narcotic administration and accounting records by Nurse # 1 for 3 of 11 sampled residents (Residents # 7, Residents # 8, and Residents # 9), and also reported a missing Oxycodone Acetaminophen pill from the facility's emergency supply of medications. The findings included:  Review of the facility's policy, revised in 11/2017,	F 607	F607  Identification: Saint Joseph of the Pines Health Center does develop and implement written policies and procedures that investigate any such allegations related to misappropriation of property.  Corrective Action Allegation of misappropriation of property was reported to appropriate state agency on 10-17-18.  Investigation of alleged misappropriation	11/16/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/09/2018

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 607	<p>Continued From page 1 and entitled, "Abuse, Neglect and/or Misappropriation of Resident Funds or Property and Exploitation Prohibition," revealed the facility would investigate any alleged cases of misappropriation of residents' property and report their investigation per state guidelines.</p> <p>1. Resident # 7 resided on the rehabilitation unit from 7/26/18 to 8/15/18. The resident's admission minimum data set (MDS) assessment, dated 8/1/18, coded Resident # 7 as cognitively intact. The resident was not coded as experiencing pain during the MDS assessment. Record review revealed Resident # 7 had an order, dated 8/1/18, for Oxycodone-Acetaminophen (narcotic medication) 5 mg-325 (milligrams) every four hours as needed for pain. Review of Resident # 7's August 2018 MAR (Medication Administration Record) revealed there were no Oxycodone-Acetaminophen doses documented on the MAR as given in the month of August, 2018. The facility used a "Controlled Medication Utilization Record" for the nurses to document dates and times the Oxycodone-Acetaminophen was removed from a resident's supply of narcotics. Review of Resident # 7's controlled medication utilization record revealed Nurse # 1 signed out 15 doses of Oxycodone-Acetaminophen between the dates of 8/2/18 and 8/9/18.</p> <p>An 8/12/18 report for the facility's emergency supply of medications was reviewed. This review revealed Nurse # 1 "returned" two Oxycodone-Acetaminophen pills for Resident # 7 on 8/12/18 at 5:36:46 AM to the facility's emergency supply of medications. Nurse # 3 signed as a witness to this transaction made by Nurse # 1.</p>	F 607	<p>included colleague interviews/ statements, in addition, to the review of medical and pharmacy records was completed on 10-24-18. Nurse #1 was suspended during investigation.</p> <p>DON will be re-educated on written policy and procedure of investigation for the prevention of abuse, neglect, and misappropriation of property to include reporting requirements by the administrator on or before 11-16-18.</p> <p>Resident #7 is discharged and medical record is closed.</p> <p>Resident #8 is discharged and medical record is closed.</p> <p>Resident #9 order for Hydrocodone-Acetaminophen was clarified within electronic medical record (EMR) on 9-26-18 from stating "as needed two times max" to "as needed every 12 hours".</p> <p>All current residents' will be reviewed for accuracy between their current Controlled Medication Utilization Record and the EMR on or before 11-16-18 by the Director of Nursing (DON) or nursing supervisor.</p> <p>System change All licensed staff will be re-educated on proper procedure of documentation of administering as needed medication by administrator or DON on or before 11-16-18. Any licensed staff member not</p>		

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F 607	Continued From page 2  Nurse # 3 was interviewed on 10/16/18 at 1:15 PM and reported the following information. On the night shift which began at 6:00 PM on 8/11/18 and ended at 6:00 AM on 8/12/18, shortly before 6:00 AM, Nurse # 1 had requested Nurse # 3 cosign for the removal of two Oxycodone-Acetaminophen pills from the facility's emergency supply for Resident # 7. According to Nurse # 3, she witnessed two pills being removed and not replaced by Nurse # 1 from the emergency supply of medications. The following evening on 8/12/18 at approximately 4:30 PM, Nurse # 3 stated she spoke to Nurse # 4 and they both looked at Resident # 7's medication order and saw that Resident # 7 only had orders for one Oxycodone-Acetaminophen every 4 hours as needed for pain. They noted Nurse # 1 had signed out 2 Oxycodone-Acetaminophen pills from the emergency supply for Resident # 7 at 5:36 AM on 8/12/18. They alerted their supervisor, and when Nurse # 3, Nurse # 4, and the supervisor checked the facility's emergency supply of medications there was a discrepancy alert on the narcotic count within the emergency supply for the number of Oxycodone-Acetaminophen pills. It noted the emergency supply was short four pills of Oxycodone-Acetaminophen. Nurse # 3 also stated that there had been other, recent instances in which she (Nurse # 3) noted a pattern of Nurse # 1 administering narcotics to residents who generally did not use them. Nurse # 3 also reported that there were times on the facility narcotic records where Nurse # 1 had signed out for more pills than prescribed for a resident. Nurse # 3 stated she had reported to the Director of Nursing (DON) in August, 2018 that she had seen a pattern, which made her suspicious that	F 607	receiving education by 11-16-18, will receive prior to working next scheduled shift.  All licensed staff will be re-educated on proper utilization of emergency medication dispense system (Omniceil) by DON, Staff Development Coordinator (SDC), or Pharmacy Account Manager by 11-16-18. Any licensed staff member not receiving education by 11-16-18, will receive prior to working next scheduled shift.  All licensed staff misappropriation of property to include reporting requirements by the administrator, DON or SDC on or before 11-16-18. Any licensed staff member not receiving education by 11-16-18, will receive prior to working next scheduled shift.  Monitoring The DON or nursing supervisor on or before 11-16-18 will audit all the as needed medication Controlled Medication Utilization Records and the EMR weekly for the next three months to determine proper administration and documentation on the medication administration record (MAR).  The administrator or DON on or before 11-16-18 will audit the Transactions by Date report from the Omnicell every business day for the next three months to review what controlled substance was removed from the Omnicell and compare to the MAR to determine proper administration and documentation.		

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F 607	Continued From page 3 Nurse # 1 was taking residents' medications.  Nurse # 4 was interviewed on 10/16/18 at 2:30 PM. Nurse # 4 reported the following information in her interview. Nurse # 4 had replaced Nurse # 1 on the morning of 8/12/18 at 6:00 AM on the rehabilitation unit. Near the end of her 8/12/18 dayshift, Nurse # 4 looked at Resident # 7's Oxycodone-Acetaminophen order. Resident # 7 had an order for only one Oxycodone-Acetaminophen. Nurse # 3 alerted Nurse # 4 near the end of the day shift that she (Nurse # 3) had cosigned when Nurse # 1 signed out two Oxycodone-Acetaminophen pills from the facility's emergency supply shortly before 6:00 AM on 8/12/18 for Resident # 7. Nurse #4 noted the facility's emergency supply of medications was checked, and there were missing Oxycodone-Acetaminophen pills in the emergency supply, which were not accounted for. The DON came in to talk to the nurses on the evening of 8/12/18 to determine why the emergency narcotic count was short. Nurse # 4 stated the DON accepted that Nurse # 1 had removed two Oxycodone-Acetaminophen pills and used one for Resident # 7 and the other to pay back Resident #8 without looking at Resident # 8's supply of Oxycodone-Acetaminophen. Nurse # 4 stated if he had looked at the narcotic card, he would have seen there was no sign that the "paid back" pill had been taped back onto Resident # 8's bubble card in anyway. Nurse # 4 stated the Oxycodone-Acetaminophen tablet was just missing. Nurse # 4 also stated Nurse # 1 never reported that there was a "paid back" Oxycodone-Acetaminophen pill for Resident # 8 from Resident # 7 during the shift change at 6 AM on 8/12/18. Nurse # 4 stated Resident # 8's narcotic count had been correct. There was not a	F 607	The administrator or DON on or before 11-16-18 will interview at least one cognitively intact resident every business day for the next three months to determine if resident has any concerns related to medication administration.  The administrator or DON on or before 11-16-18 will interview at least one licensed staff member every business day for one month, then weekly for two months to determine if staff member has any concerns related to misappropriation of property or medication administration.  The DON will report trends of these audits to the Mission Driven Quality Assurance and Performance Improvement (MD-QAPI) Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee.  The DON is responsible for attaining and sustaining compliance.  The facility alleges compliance effective 11-16-18.	

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F 607	<p>Continued From page 4</p> <p>loose pill in the narcotic drawer, and there had been no narcotic accounting sheet for an extra pill of Oxycodone-Acetaminophen. Nurse # 4 stated she also spoke to both Resident # 7 and Resident # 8 on 8/12/18. The nurse stated she asked general questions about pain management, and asked what they had been using for pain control. Nurse # 4 stated both Resident # 7 and Resident # 8 reported they had not taken any Oxycodone-Acetaminophen on the night shift which began at 6:00 PM on 8/11/18 to 6:00 AM on 8/12/18, and on which Nurse # 1 removed the Oxycodone-Acetaminophen from the facility's emergency supply for their use. Nurse # 4 reported she had told the DON in August, 2018 that she suspected Nurse # 1 of taking residents' pain medications.</p> <p>Nurse # 5 was an administrative nurse. Nurse # 5 was interviewed on 10/16/18 at 10:30 AM and reported the following. Nurse # 5 reported she was called at home on the evening of 8/12/18 by Nurse # 3, who was very upset about having cosigned for a narcotic medication that was missing after being signed out by Nurse # 1. Nurse # 5 was aware that the DON had talked to Nurse # 1 about the two Oxycodone-Acetaminophen pills, which Nurse # 1 had signed out from the facility's emergency supply on 8/12/18 at 5:36 AM for Resident # 7 and this resident only had an order for one. Nurse # 5 was also aware that Nurse # 1's explanation was that the extra pill was "paid back" to Resident # 8. Nurse # 5 reported there was never any "paid back" pill found for Resident # 8, and as of the current date of 10/16/18 there had never been an accounting for the "paid back" pill. Nurse # 5 stated, "It was just missing." Nurse # 5 also reported that she went into work on 8/13/18 and</p>	F 607			

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F 607	<p>Continued From page 5</p> <p>spoke to Resident # 7 and Resident # 8, who both reported to her that they had not taken any Oxycodone-Acetaminophen on the shift which began at 6 PM on 8/11/18 and ended at 6 AM on 8/12/18. Nurse # 5 stated she suspected Nurse # 1 was taking residents' narcotic medications. She had expressed to the DON in August 2018 this concern, along with her concern that the 8/12/18 Oxycodone-Acetaminophen pills from the emergency supply had been diverted by Nurse # 1. Nurse # 5 stated the DON had felt as if it was a documentation issue, and not a diversion issue. He had required random audits following the date of 8/12/18 to determine if nurses were documenting on the MAR when they administered narcotics. According to Nurse # 5 she had been helping with the ongoing audits. Nurse # 5 had seen a pattern where Nurse # 1 administered more medications to residents who generally did not ask for them when compared to times when other nurses worked. Nurse # 5 stated she gave the DON her audits.</p> <p>The DON was interviewed on 10/16/18 at 9:20 AM, 10/16/18 at 4:30 PM, and again on 10/17/18 at 1 PM. During these interviews the DON reported the following. It was his expectation that nurses document on the MAR at the same time they remove narcotics from a resident's supply, and the reason they are administering them. He had been alerted by Nurse # 3 on the week-end evening of 8/12/18 that the facility's emergency medication supply was showing a discrepancy in the narcotics. He came to the facility and did a review of entries at that time. He determined that Nurse # 1 had inadvertently entered she was "returning" two Oxycodone-Acetaminophen pills when she had actually removed two pills. Therefore the facility's emergency narcotic count</p>	F 607			

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F 607	Continued From page 6 was showing the narcotic count was short four pills when it had not been. The DON talked to Nurse # 1, Nurse # 3, and Nurse # 4 on that evening. Nurse # 3 and # 4 were concerned because the pills that Nurse # 1 had removed on 8/12/18 were intended for Resident # 7, who had an order for only one pill. The DON stated he had talked to Nurse # 1 about it, and she had explained that she borrowed earlier in her shift when there was no nurse to cosign for removal of an Oxycodone-Acetaminophen pill. Therefore, the DON stated Nurse # 1 had "paid back" the resident from whom she had borrowed. The DON acknowledged that it was not an acceptable professional nursing practice to do this, but stated he did not think Nurse # 1 had taken the Oxycodone-Acetaminophen. He was aware that Nurse # 3 and Nurse # 4 had talked to Resident #7 and Resident #8, who had claimed they had not requested or received the Oxycodone-Acetaminophen on the shift which went from 6:00 PM on 8/11/18 to 6:00 AM on 8/12/18. He had not talked to the residents himself because he did not consider resident interviews reliable. The DON stated Nurse # 1 had worked at the facility for many years, and he did not think she would take residents' medications and thought it was more of a documentation issue. According to the DON, the facility had converted to a new computer system for their electronic records and there had been problems with multiple nurses not documenting the administration of narcotics on the MAR. According to the DON, he had taken statements from Nurse # 3 and Nurse # 4 in regards to the facility emergency narcotic discrepancy on 8/12/18, and those were the only statements he had obtained for investigation into narcotic problems. The DON was not able to find the	F 607			

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F 607	<p>Continued From page 7</p> <p>statements from 8/12/18 which he had taken. The DON was interviewed regarding whether he had personally talked to any residents regarding suspected diversion, and he reported he had not done so. The DON stated he had been contacted by the NC Board of Nursing (NCBON), who had requested more information regarding the discrepancy in the facility's emergency narcotic medications. The DON stated he had supplied this information to the NCBON, but in gathering the requested information he had not noticed a pattern of Nurse # 1 administering medications that were not documented on the MAR more than any other nurse. The DON did not feel the narcotic documentation audits, which were being done, had shown a problem with Nurse # 1.</p> <p>Interview with an administrative pharmacist on 10/16/18 at 4:47 PM, for the pharmacy used by the facility, revealed that it was their expectation that the facility notify them if allegations of narcotic diversion were made. The pharmacist stated the pharmacy then works with the facility to develop a plan to investigate the possible diversion.</p> <p>Interview with the facility Administrator on 10/17/18 at 8:30 AM revealed he had not been aware there had been allegations of residents' narcotics being diverted. The Administrator stated he was aware the NCBON had contacted the DON about a discrepancy in the facility's emergency narcotics, but that there was an explanation for the discrepancy which was reported back to the NCBON. The Administrator stated he thought the issue had been resolved. He had not considered the NCBON's inquiry was an allegation of diversion. According to the Administrator, any employee who was suspected</p>	F 607			



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F 607	<p>Continued From page 8</p> <p>of misappropriating residents' items was to be suspended and a full investigation was to be done and reported to the appropriate agencies. According to the Administrator, an investigation and reporting had not been done, since he had not been aware of the situation. According to the administrator an investigation was warranted based on their policy.</p> <p>On 10/17/18 at 11:30 AM, Nurse # 1 was interviewed via phone. The DON and Administrator were also present in the room as the call was placed to Nurse # 1. Nurse # 1 referred to taking care of Resident # 7 and Resident # 8 on the night shift which began on 8/11/18 at 6:00 PM and ended at 6:00 AM on 8/12/18. Nurse # 1 reported that earlier in the shift, she had given Resident # 7 one of Resident # 8's Oxycodone-Acetaminophen because she could not find a nurse to cosign for her from the facility's emergency supply. Later she removed two Oxycodone-Acetaminophen pills from the facility's emergency supply and "paid back" Resident #8. Nurse # 1 stated there had been problems documenting on the new computer electronic MARs the administration of the medication. According to the nurse at times you could not pull the PRN pain orders up on the computerized MAR screen to see the order and document. Nurse # 1 had no explanation why Resident # 7 had reported she had not received one of the Oxycodone-Acetaminophen pills, which Nurse # 1 had removed from the emergency supply on 8/12/18. Nurse # 1 stated she had given it to Resident # 7. Nurse # 1 also did not know what had happened to the second Oxycodone-Acetaminophen pill she removed from the facility's emergency supply to pay back Resident # 8.</p>	F 607			

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F 607	<p>Continued From page 9</p> <p>On 10/19/18 at 3:00 PM it was verified with the Administrator that the facility could not produce evidence the Oxycodone-Acetaminophen pills, which had been removed from the emergency medication supply by Nurse # 1 on 8/12/18 at 5:36 AM, were ever administered to any resident or accounted for anyway. The Administrator also acknowledged that if there had been a "paid back" Oxycodone-Acetaminophen pill for Resident # 8 then there should have been an extra Oxycodone-Acetaminophen pill at shift change on 8/12/18 at 6:00 AM, and it had never been found.</p> <p>2. Record review revealed Resident # 8 had resided on the rehabilitation unit from 8/8/18 to 8/24/18. Record review for Resident #8 revealed the following. The resident's admission MDS assessment, dated 8/21/18, coded the resident as cognitively intact. Resident # 8 had an order, dated 8/8/18, for two Oxycodone-Acetaminophen 5 mg-325 mg pills to be administered every four hours as needed for pain. On 8/9/18 this order was decreased to one Oxycodone-Acetaminophen 5 mg-325 mg pill every four hours as needed for pain. Nurse # 1 signed out for 16 of the 17 times the resident's Oxycodone-Acetaminophen was signed out on the controlled medication utilization record from 8/8/16 through 8/16/18. From 8/10/18 through 8/12/18 Nurse # 1 signed out more pills than were prescribed. During these dates, on eight different times she signed as removing two Oxycodone-Acetaminophen pills from the resident's supply rather than the prescribed one pill.</p> <p>Review of Resident # 8's August, 2018 MAR</p>	F 607			

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F 607	<p>Continued From page 10</p> <p>revealed none of the Oxycodone-Acetaminophen pills were documented by Nurse # 1 as removed from his supply from 8/8/18 to 8/12/18 were documented on the MAR.</p> <p>Review of an 8/12/18 report for the facility's emergency supply of medications was reviewed. This review revealed Nurse # 1 "returned" two Oxycodone-Acetaminophen for Resident # 7 on 8/12/18 at 5:36:46 AM to the facility's emergency supply of medications.</p> <p>According to an interview with the DON (Director of Nursing) on 10/16/18 at 9:20 AM and Nurse # 1 on 10/17/18 at 11:30 AM, Nurse # 1 had removed the pills and not returned them when she signed for this transaction for Resident #7. Both the DON and Nurse # 1 stated one of the pills was used for Resident # 8 instead of Resident #7. Nurse # 1 stated she "paid back" the pill to Resident # 8 because she had borrowed from his supply earlier in her shift.</p> <p>Nurse # 4 was interviewed on 10/16/18 at 2:30 PM. According to Nurse # 4 she had replaced Nurse # 1 for duty on 8/12/18 at 6:00 AM. Nurse # 4 stated there was no "paid back" pill for Resident #8 found on his card or in the drawer at 6:00 AM on 8/12/18, and Nurse # 1 had never mentioned a "paid back" pill during shift change. Nurse # 4 also stated she had spoken to Resident # 8 on the evening of 8/12/18 and Nurse # 4 reported he had not taken any Oxycodone-Acetaminophen on the shift which began at 6:00 PM on 8/11/18 and ended at 6:00 AM on 8/12/18. Nurse # 4 stated she had reported to the DON in August, 2018 that she suspected Nurse # 1 was taking residents' narcotics. According to Nurse # 4, if the DON</p>	F 607			

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F 607	<p>Continued From page 11</p> <p>had looked at Resident # 8's Oxycodone-Acetaminophen narcotic supply and accounting sheet, he would have seen there was never any "paid back" pill.</p> <p>Nurse # 5 was interviewed on 10/16/18 at 10:30 AM. Nurse # 5 also reported that she went into work on 8/13/18 and spoke to Resident # 8, who reported to her that he had not taken any Oxycodone-Acetaminophen on the shift which began at 6 PM on 8/11/18 and ended at 6 AM on 8/12/18. Nurse # 5 stated she suspected Nurse # 1 was taking residents' narcotic medications. She had expressed to the DON in August 2018 this concern, along with her concern that the 8/12/18 Oxycodone-Acetaminophen pills, which had been removed by Nurse # 1 from the emergency supply, had been diverted by Nurse # 1, and there was no explanation for the missing Oxycodone-Acetaminophen.</p> <p>The DON was interviewed on 10/16/18 at 9:20 AM, 10/16/18 at 4:30 PM, and again on 10/17/18 at 1 PM. During these interviews the DON reported the following. It was his expectation that nurses document on the MAR at the same time they remove narcotics from a resident's supply, and the reason they are administering them. The DON acknowledged that it was not an acceptable professional nursing practice to "pay back" narcotics, but stated he did not think Nurse # 1 had taken the Oxycodone-Acetaminophen from residents or the emergency supply. He had not talked to the residents himself about any suspected diversions because he did not consider resident interviews reliable. The DON stated Nurse # 1 had worked at the facility for many years, and he did not think she would take residents' medications and he thought it was</p>	F 607			

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F 607	<p>Continued From page 12</p> <p>more of a documentation issue. According to the DON, the facility had converted to a new computer system for their electronic records and there had been problems with multiple nurses not documenting the administration of narcotics on the MAR. According to the DON, he had not taken nurses' statements about the missing "paid back" pill on 8/12/18 or contacted the pharmacy about any suspected diversion.</p> <p>Interview with an Administrative Pharmacist on 10/16/18 at 4:47 PM, for the pharmacy used by the facility, revealed that it was their expectation that the facility notify them if allegations of narcotic diversion were made. The pharmacist stated the pharmacy then works with the facility to develop a plan to investigate the possible diversion.</p> <p>Interview with the facility Administrator on 10/17/18 at 8:30 AM revealed he had not been aware there had been allegations of residents' narcotics being diverted. According to the Administrator, any employee who was suspected of misappropriating residents' items was to be suspended and a full investigation was to be done and reported to the appropriate agencies. According to the administrator, an investigation and reporting had not been done, since he had not been aware of the situation. According to the administrator an investigation was warranted based on their policy.</p> <p>During the interview with Nurse # 1 on 10/17/18 at 11:30 AM, Nurse # 1 also reported she had been experiencing computer problems in documenting PRN pain medication administration on residents' MARs. According to Nurse # 1, she had given one of the two</p>	F 607			

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F 607	<p>Continued From page 13</p> <p>Oxycodone-Acetaminophen pills, which she had removed from the emergency supply on 8/12/18, to Resident # 7. The nurse stated she had "paid back" the other pill to Resident #8. The nurse had no explanation where the missing "paid back" Oxycodone-Acetaminophen had gone.</p> <p>On 10/19/18 at 3:00 PM it was verified with the Administrator that the facility could not produce evidence the Oxycodone-Acetaminophen pills, which had been removed from the facility's emergency supply by Nurse # 1 on 8/12/18 at 5:36 AM, were ever administered to any resident or accounted for anyway. The Administrator also acknowledged that if there had been a "paid back" Oxycodone-Acetaminophen pill for Resident # 8 then there should have been an extra Oxycodone-Acetaminophen pill at shift change on 8/12/18 at 6:00 AM, and it had never been found.</p> <p>3. Resident # 9 was admitted to the facility on 1/14/18. The resident's MDS assessment, dated 7/16/18, coded the resident as cognitively impaired. The resident was not coded as having pain during the assessment period. Resident # 9 had a prescription, dated 4/26/18, for Norco 5-325 mg every 12 hours via gastrostomy tube as needed for pain. Review of the May 2018 monthly physician orders revealed the Norco order was entered into the resident's facility electronic record as Hydrocodone-Acetaminophen 5-325 mg (which is the other name for Norco) to be administered two times as needed (PRN) for severe pain. There was a notation "two times max" written in place of time frequency. Review of Resident # 9's controlled medication utilization record for the Hydrocodone Acetaminophen revealed it was</p>	F 607			

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F 607	<p>Continued From page 14</p> <p>signed out a total of 10 times during the month of September, 2018. Two of these times were by Nurse # 1 within a 5.75 hour time period. The times were 9/21/18 at 11:30 PM and 9/22/18 at 5:15 AM. There was no documentation on the resident's MAR to coincide with the removal of the Hydrocodone-Acetaminophen from the resident's narcotic supply by Nurse # 1.</p> <p>Nurse # 5 was an administrative nurse. Nurse # 5 was interviewed on 10/16/18 at 10:30 AM and reported the following. Nurse # 5 suspected Nurse # 1 was taking residents' narcotic medications and she had spoken to the DON in August, 2018 about her suspicions and the DON thought it was more of a documentation issue, and requested audits. Nurse # 5 stated Resident #9 was an example of a resident who had shown up on their audit. According to Nurse # 5, Nurse # 1 did not routinely work on Resident # 9's unit. In September, Nurse # 1 had been required to work on Resident #9's unit in September one night. On that night Nurse # 1 removed Resident # 9's narcotics twice that night from his supply. According to Nurse # 5 this did not match Resident # 9's past history of narcotic use, and she was concerned. According to Nurse # 5, she had been doing audits since August, 2018. She had given the audit which pertained to Resident #9 to the DON in September, 2018.</p> <p>The DON was interviewed on 10/16/18 at 9:20 AM, 10/16/18 at 4:30 PM, and again on 10/17/18 at 1:00 PM. During these interviews the DON reported the following. It was his expectation that nurses document on the MAR at the same time they remove narcotics from a resident's supply, and the reason they are administering them. The DON was aware that some nurses thought that</p>	F 607			

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F 607	<p>Continued From page 15</p> <p>Nurse # 1 was taking narcotics. The DON stated he thought it was more of a documentation issue, and no diversion was occurring. According to the DON, the facility had converted to a new computer system for their electronic records and there had been problems with multiple nurses not documenting the administration of narcotics on the MAR. He had required audits be done following the date of 8/12/18. The DON was aware Nurse # 1 had been flagged in a September, 2018 audit when she was pulled to Resident # 9's floor. The DON stated Resident # 9 had cyclical times in which he yelled out, and required pain medication. In looking at Resident # 9's audit, he had determined the computerized order was not clear, and therefore could not prove she had diverted the medication. According to the DON he was still accumulating audits and reviewing them. The DON was also aware that some of the nurses had spoken to residents who claimed they had not received narcotics which Nurse # 1 had signed out from their supply of narcotics. According to the DON, he did not find resident interviews completely credible, and he had not personally spoken to residents who had reported this. The DON also stated he had not notified the facility's pharmacy that there was suspected drug diversion, and he had not involved the pharmacy in any type of investigation.</p> <p>Interview with an Administrative Pharmacist on 10/16/18 at 4:47 PM, for the pharmacy used by the facility, revealed that it was their expectation that the facility notify them if allegations of narcotic diversion were made. The pharmacist stated the pharmacy then works with the facility to develop a plan to investigate the possible diversion.</p>	F 607			



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F 607	Continued From page 16  Interview with the facility Administrator on 10/17/18 at 8:30 AM revealed he had not been aware there had been allegations of residents' narcotics being diverted. According to the Administrator, any employee who was suspected of misappropriating residents' items was to be suspended and a full investigation was to be done and reported to the appropriate agencies. According to the Administrator, an investigation and reporting had not been done, since he had not been aware of the situation. According to the administrator an investigation was warranted based on their policy.	F 607			
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)  §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-  §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		11/16/18	

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F 755	<p>Continued From page 17 the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure a system of accurate narcotic accounting for three (Residents # 7, # 8, and #9) of three sampled residents and for the facility's emergency supply of narcotics. The findings included:</p> <p>1. Record review revealed Resident # 7 had resided on the rehabilitation unit from 7/26/18 to 8/15/18.</p> <p>The resident's minimum data set (MDS) assessment, dated 8/1/18, coded Resident # 7 as cognitively intact. The resident was not coded as experiencing pain during the MDS assessment.</p> <p>Record review revealed Resident # 7 had an order, dated 8/1/18, for Oxycodone-Acetaminophen 5 mg-325 (milligrams) every four hours as needed for pain.</p> <p>Review of Resident # 7's August 2018 MAR (Medication Administration Record) revealed there were no Oxycodone-Acetaminophen doses documented on the MAR as given in the month of August, 2018.</p> <p>Review of nursing notes from 8/1/18 to 8/15/18</p>	F 755	<p>F755 Identification St. Joseph of the Pines does have a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.</p> <p>Corrective Action Resident #7 is discharged and medical record is closed.</p> <p>Resident #8 is discharged and medical record is closed.</p> <p>Resident #9 order for Hydrocodone-Acetaminophen was clarified within electronic medical record (EMR) on 9-26-18 from stating "as needed two times max" to "as needed every 12 hours".</p> <p>All current residents' will be reviewed for accuracy between their current Controlled Medication Utilization Record and the EMR on or before 11-16-18 by the DON or nursing supervisor.</p>		

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F 755	<p>Continued From page 18</p> <p>revealed there were no entries noting date and times of Oxycodone-Acetaminophen administration.</p> <p>The facility used a "Controlled Medication Utilization Record" for the nurses to document dates and times the Oxycodone-Acetaminophen was removed from a resident's supply of narcotics. Review of Resident # 7's controlled medication utilization record revealed Nurse # 1 signed out 15 doses of Oxycodone-Acetaminophen between the dates of 8/2/18 and 8/9/18. The dates and times were as follows:</p> <p>8/2/18 at 6:10 PM 8/2/18 at 10:00 PM 8/3/18 at 1:40 AM 8/3/18 at 5:30 AM 8/5/18 at 6:15 PM 8/5/18 at 10:00 PM 8/6/18 at 1:55 AM 8/6/18 at 6:15 PM 8/6/18 at 10:05 PM 8/7/18 at 1:45 AM (there was a line drawn through the date and time of this entry with no explanation; the pill was still noted as removed on the descending count) 8/7/18 at 5:20 AM 8/8/18 (no time documented) 8/8/18 at 6:20 PM 8/8/18 at 10:00 PM 8/9/18 at 1:35 AM</p> <p>No other nurse signed out any of Resident # 7's Oxycodone-Acetaminophen from her supply.</p> <p>Interview with the Director of Nursing (DON) on 10/17/18 at 1 PM revealed it was his expectation that nurses document the date, time, and reason</p>	F 755	<p>System change All licensed staff will be re-educated on proper procedure of documentation of administering as needed medication by administrator or DON on or before 11-16-18. Any licensed staff member not receiving education by 11-16-18, will receive prior to working next scheduled shift.</p> <p>All licensed staff will be re-educated on proper utilization of emergency medication dispense system (Omniceil) by DON, SDC, or Pharmacy Account Manager by 11-16-18. Any licensed staff member not receiving education by 11-16-18, will receive prior to working next scheduled shift.</p> <p>Monitoring The DON or nursing supervisor on or before 11-16-18 will audit all the as needed medication Controlled Medication Utilization Records and the EMR weekly for the next three months to determine proper administration and documentation on the medication administration record (MAR).</p> <p>The administrator or DON on or before 11-16-18 will audit the Transactions by Date report from the Omnicell every business day for the next three months to review what controlled substance was removed from the Omnicell and compare to the MAR to determine proper administration and documentation.</p>		

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F 755	<p>Continued From page 19</p> <p>narcotics are administered on a resident's MAR. According to the DON, the facility had been experiencing problems with their new computer system for medication administration documentation. In the instances noted above, the DON felt there was a documentation issue involved and not a diversion. According to the DON, if a nurse encountered problems with the MAR computer system, it was his expectation they should enter the date and time of narcotic administration in the nursing notes.</p> <p>Nurse # 5 was interviewed on 10/16/18 at 10:30 AM. Nurse # 3 was interviewed on 10/16/18 at 1:15 PM. Nurse # 4 was interviewed on 10/16/18 at 2:30 PM. During these interviews, these three nurses stated they suspected Nurse # 1 was taking residents' narcotic medications based on a pattern they had witnessed in which Nurse # 1 medicated residents who did not generally ask for pain medication from other nurses. They also all three stated there had been an unaccounted Oxycodone- Acetaminophen 5 mg-325 (milligrams) pill which was unaccounted for from the facility's emergency supply, and which had been removed by Nurse # 1 on 8/12/18. According to the nurses the emergency medication transaction was made for Resident # 7. According to the three nurses, the Oxycodone-Acetaminophen pill was missing without any evidence of documentation it was administered to anyone or any accounting records for it.</p> <p>An 8/12/18 report for the facility's emergency supply of medications was reviewed. This review revealed Nurse # 1 "returned" two Oxycodone-Acetaminophen for Resident # 7 on 8/12/18 at 5:36:46 AM to the facility's emergency</p>	F 755	<p>The DON will report trends of these audits to the Mission Driven Quality Assurance and Performance Improvement (MD-QAPI) Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee.</p> <p>The DON is responsible for attaining and sustaining compliance. The facility alleges compliance effective 11-16-18.</p>		

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F 755	<p>Continued From page 20</p> <p>medication supply. A discrepancy notice was documented in the narcotic count report following this transaction on the emergency medication supply.</p> <p>During an interview with the DON on 10/16/18 at 9:20 AM, the DON reported the following. The DON came to the facility on the evening of 8/12/18 and did a review of the facility's emergency medication supply entries at that time. He determined that Nurse # 1 had inadvertently entered she was "returning" two Oxycodone-Acetaminophen pills when she had actually removed two pills. Therefore the facility's emergency medication supply count was showing the narcotic count was short four pills when it had not been. Nurse # 1 reported to the DON she had removed two pills instead of the one pill ordered for Resident # 7 because she had borrowed from another resident's narcotic supplies earlier in the shift. Therefore, the DON stated Nurse # 1 had "paid back" the resident, from whom she had borrowed, with the extra pill she had removed from the emergency medication supply. The DON acknowledged that it was not an acceptable professional nursing practice to do this, but stated he did not think Nurse # 1 had taken the Oxycodone-Acetaminophen.</p> <p>Nurse # 1 was interviewed on 10/17/18 at 11:30 AM. Nurse # 1 stated she had borrowed a "male" resident's narcotic medication earlier on her shift, which was from 6:00 PM on 8/11/18 to 6:00 AM of 8/12/18. The nurse stated she used the borrowed narcotic for a "female" resident. Nurse # 1 stated she then removed two Oxycodone-Acetaminophen pills from the facility's emergency medication supply at near the end of her shift. She stated she gave one to the female</p>	F 755			

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F 755	<p>Continued From page 21</p> <p>resident and then "paid back" the male resident. She stated the male resident, for whom she borrowed, had resided in the room in which Resident # 8 resided. The nurse did not know where the "paid back" Oxycodone-Acetaminophen had gone.</p> <p>Review of Resident # 8's narcotic records, MAR, and nursing notes revealed no accounting record for the Oxycodone-Acetaminophen pill removed by Nurse # 1 on 8/12/18 at 5:36 AM and for which the nurse indicated she had "paid him back."</p> <p>Review of Resident #8's Controlled Medication Utilization Record revealed Nurse # 1 had signed out the maximum number of pills per his order allowed by 5:20 AM on 8/12/18. The "paid back" pill was removed from the emergency medication supply at 5:36 AM on 8/12/18; indicating that the "paid back pill" would not have been administered by Nurse # 1 and should have shown up somewhere.</p> <p>Interview with Nurse # 4 on 10/16/18 at 2:30 PM revealed she had replaced Nurse # 1 on 8/12/18 at 6:00 AM, and there was no "paid back" Oxycodone-Acetaminophen pill for Resident # 8, nor was there an accounting sheet for it.</p> <p>Interview with the facility administrator on 10/17/18 at 8:30 AM revealed he had not been aware there had been allegations of residents' narcotics being diverted. The administrator was unable to show that the facility's current system of documenting the removal and administration of narcotic medications provided an accurate accounting of narcotics.</p> <p>On 10/19/18 at 3 PM it was verified with the administrator that the facility could not produce evidence the Oxycodone-Acetaminophen pills,</p>	F 755			

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F 755	<p>Continued From page 22</p> <p>which had been removed by Nurse # 1 on 8/12/18 at 5:36 AM, were ever administered to any resident or accounted for anyway. The administrator also acknowledged that if there had been a "paid back" Oxycodone-Acetaminophen pill for Resident # 8 then there should have been an extra Oxycodone-Acetaminophen pill at shift change on 8/12/18 at 6:00 AM, and it had never been found.</p> <p>2. Record review revealed Resident # 8 had resided on the rehabilitation unit from 8/8/18 to 8/24/18. Record review for Resident #8 revealed the following.</p> <p>The resident's admission MDS assessment, dated 8/21/18, coded the resident as cognitively intact.</p> <p>Resident # 8 had an order, dated 8/8/18, for two Oxycodone-Acetaminophen 5 mg-325 mg pills to be administered every four hours as needed for pain. On 8/9/18 this order was decreased to one Oxycodone-Acetaminophen 5 mg-325 mg pill every four hours as needed for pain.</p> <p>Resident # 8 also had an order, dated 8/8/18, for Tylenol 650 mg every six hours as needed for pain.</p> <p>Review of Resident # 8's MAR revealed he was documented as receiving Oxycodone-Acetaminophen 5 mg-325 mg three times during the month of August, 2018. These were 8/21/18 at 12:15AM 8/21/18 at 1:45 PM 8/22/18 at 4:56 PM</p>	F 755			

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FORM APPROVED  
OMB NO. 0938-0391

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F 755	<p>Continued From page 23</p> <p>The facility used a "Controlled Medication Utilization Record" for the nurses to document dates and times the Oxycodone-Acetaminophen was removed from a resident's supply of narcotics. Review of Resident # 8's controlled medication utilization record revealed the resident's Oxycodone-Acetaminophen was removed from his supply of narcotics 22 times without documentation on the MAR. Nine times between the dates of 8/10/18 and 8/12/18, two Oxycodone-Acetaminophen pills were signed out rather than the prescribed one pill. The twenty-two times which did not appear on the MAR are as follows:</p> <p>8/8/18 at 6:40 PM-(Nurse # 1 signed out two) 8/8/18 at 10:30 PM- (Nurse # 1 signed out two) 8/9/18 at 2:10 AM-(Nurse # 1 signed out two) 8/9/18 at 5:45 AM-(Nurse # 1 signed out two) 8/10/18 at 6:20 PM-(Nurse # 1 signed out two) 8/10/18 at 10:00 PM -(Nurse # 1 signed out two) 8/11/18 at 1:50 AM-(Nurse # 1 signed out two) 8/11/18 at 5:15 AM-(Nurse # 1 signed out two) 8/11/18 at 6:15 PM-(Nurse # 1 signed out two) 8/11/18 at 10 PM-(Nurse # 1 signed out two) 8/12/18 at 1:45 AM-(Nurse # 1 signed out two) 8/12/18 at 5:20 AM-(Nurse # 1 signed out two) 8/12/18 at 11 PM-(Nurse # 6 signed out two) 8/15/18 at 7:10 PM-(Nurse # 1 signed out one) 8/16/18 at 3:30 AM-(Nurse # 1 signed out one) 8/16/18 at 6:20 PM-(Nurse # 1 signed out one) 8/16/18 at 10:30 PM-(Nurse # 1 signed out one) 8/17/18 at 2:15 AM-(Nurse # 1 signed out one) 8/17/18 at 9:45 AM (Nurse # 7 signed out one) 8/18/18 at 5 PM-(Nurse # 7 signed out one) 8/18/18 at 10 PM-(Nurse # 7 signed out one) 8/23/18 at 10:15 AM-(Nurse # 8 signed out one)</p> <p>Interview with the Director of Nursing (DON) on 10/17/18 at 1 PM revealed it was his expectation</p>	F 755			



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F 755	<p>Continued From page 24</p> <p>that nurses document the date, time, and reason narcotics are administered on a resident's MAR. According to the DON, the facility had been experiencing problems with their new computer program for medication administration documentation. In the instances noted above, the DON felt there was a documentation issue involved and not a diversion. According to the DON, if a nurse encountered problems with the MAR computer system, it was his expectation they should enter the date and time of narcotic administration in the nursing notes.</p> <p>Further review of the record revealed that within the resident's nursing notes, dated from 8/8/18 to 8/24/18, there were no notations documenting the time, date, and administration of the Oxycodone-Acetaminophen. On any occasions on which a nurse documented in the nursing notes about Resident #8's pain during his residency, the nurses did not distinguish between whether they had administered Tylenol or Oxycodone-Acetaminophen.</p> <p>3. Record review revealed Resident # 9 was admitted to the facility on 1/14/18.</p> <p>The resident's MDS assessment, dated 7/16/18, coded the resident as cognitively impaired. The resident was not coded as having pain during the assessment period.</p> <p>Record review revealed an electronic order, initiated on 4/13/18, for Hydrocodone-Acetaminophen 5-325 mg to be administered two times max (PRN) for severe pain. This order remained in effect until an order on 9/26/18, which was for Hydrocodone Acetaminophen 5-325 mg every twelve hours as</p>	F 755			

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F 755	<p>Continued From page 25 needed for severe pain.</p> <p>It was clarified with the administrator on 10/19/18 at 3 PM that the intent of the physician's order in April, 2018 was for the Hydrocodone-Acetaminophen to be administered every 12 hours as needed for pain. The administrator stated with the new computerized medical records, the nurse who had entered the order had inadvertently put two times maximum rather than every twelve hours. The administrator provided a copy of a physician's prescription, which had been sent to the pharmacy and which was dated 4/26/18, for Resident # 9. The prescription was for Hydrocodone-Acetaminophen to be administered every 12 hours as needed for pain.</p> <p>Review of the Resident's September and October, 2018 Medication Administration Record (MAR) revealed the resident was documented as receiving the Hydrocodone-Acetaminophen eleven times between the dates of 9/4/18 and 10/16/18.</p> <p>The facility used a "Controlled Medication Utilization Record" for the nurses to document dates and times the Hydrocodone-Acetaminophen was removed from a resident's supply of narcotics. Review of Resident # 9's controlled medication utilization record revealed the resident's Hydrocodone-Acetaminophen was removed from his supply of narcotics 17 times. There was no documentation on the MAR which corresponded to 6 of the 17 times it was removed. The times were as follows: On 9/4/18 at 9 AM (Nurse # 9 removed one pill) On 9/11/18 at 10 AM (Nurse # 9 removed one pill) On 9/21/18 at 11:30 PM (Nurse # 1 removed one</p>	F 755			

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F 755	Continued From page 26 pill) On 9/22/18 at 5:15 AM (Nurse # 1 removed one pill) On 10/9/18 at 10 AM (Nurse # 9 removed one pill) On 10/16/18 at 12:00 PM (Nurse # 9 removed one pill)  Interview with the Director of Nursing (DON) on 10/17/18 at 1 PM revealed it was his expectation that nurses document the date, time, and reason narcotics are administered on a resident's MAR. According to the DON, the facility had been experiencing problems with their new computer program for medication administration documentation. In the instances noted above, the DON felt there was a documentation issue involved and not a diversion. According to the DON, if a nurse encountered problems with the MAR computer system, it was his expectation they should enter the date and time of narcotic administration in the nursing notes for accounting purposes.  Review of the resident's nursing notes from 9/4/18 to 10/16/18 revealed no documentation noting the administration of the Hydrocodone-Acetaminophen for the six times it was removed from the resident's narcotic supply and not documented on the MAR.	F 755			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)  §483.45(f) Medication Errors. The facility must ensure that its-  §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		11/16/18	

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F 759	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview the facility failed to assure it was free of medication error rates less than 5%. Two nurses on one of the facility's seven units were observed as they administered medications. There were two medication errors made out of twenty-five opportunities for error resulting in an eight percent medication error rate. The findings included:</p> <p>1. Record review on 10/16/18 revealed Resident # 11 had a current order for Nifedipine Extended Release 30 mg (milligrams) every day for hypertension and heart failure.</p> <p>Nurse # 9 was observed as she administered this medication to Resident # 11 on 10/16/18 at 8:30 AM. Nurse # 9 was observed to crush the extended release medication, and administer it to the resident. Immediately following the administration, the supply of Nifedipine Extended Release medication was observed again with Nurse # 11. On the Nifedipine Extended Release supply of medication, there was a pharmacy label noting that the medication should not be crushed. It was observed that part of this label had not printed entirely, thereby making all the letters in the label not completely legible.</p> <p>Interview with the nurse on 10/16/18 at 8:47 AM regarding the Nifedipine Extended Release medication administration revealed she had not seen the label.</p> <p>Crushing of an extended release medication resulting in a medication error.</p>	F 759	<p>F759</p> <p>Identification St. Joseph of the Pines does ensure the medication error rate is not five percent or greater.</p> <p>Corrective Action Nurse #9 was re-educated on proper procedure of administering medications to include list of most common medications not-to-crush by DON on or before 11-16-18</p> <p>The DON or nursing supervisor will review all current residents' medications to identify and correct any pharmacy warning label that was illegible on or before 11-16-18.</p> <p>System Change All licensed staff will be re-educated on proper procedure of administering medications to include list of most common medications not-to-crush by DON, SDC, or Pharmacy Account Manager by 11-16-18. Any licensed staff member not receiving education by 11-16-18, will receive prior to working next scheduled shift.</p> <p>Monitoring The DON, SDC, or nursing supervisor on or before 11-16-18 will observe one nurse administer medications to five residents daily for one month, then one nurse administer medication to one resident</p>		

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F 759	<p>Continued From page 28</p> <p>2. Record review revealed Resident # 11 had an order, dated 6/15/18 for Isosorbide Mononitrate Extended Release 30 mg (milligrams) to be given every morning for a diagnosis of cerebrovascular disease.</p> <p>Nurse # 9 was observed as she prepared and administered morning medications to Resident #9 on 10/16/18 at 8:30 AM. Nurse # 9 was observed to prepare seven medications for administration for Resident # 11. Nurse # 9 was not observed to prepare and administer Resident # 9's Isosorbide Mononitrate Extended Release medication before she moved onto her next resident at 8:50 AM.</p> <p>Record review revealed the nurse signed she gave the Isosorbide Mononitrate Extended Release medication with Resident # 9's other seven medications. This resulted in an error of omission.</p> <p>On 10/16/18 at 12:40 AM the medication errors were discussed with the Director of Nursing. According to the DON, some nurses had been experiencing problems with the facility's new computer medication administration system in regards to how the system populated on the screen what medications needed to be given. The DON did not know if a computer problem had contributed to Nurse # 9's omission error, but was aware there had been reported issues with the system.</p> <p>The omission error was discussed with Nurse # 9 on 10/16/18 at 2:20 PM to determine if there were any contributing factors to the medication error. The nurse was not able to recall the details of making the error.</p>	F 759	<p>daily for one month, and then one nurse administer medication to one resident weekly for one month.</p> <p>The DON will report trends of these audits to the MD-QAPI Committee monthly for review and recommendation until substantial compliance is achieved or as directed by the MD-QAPI Committee.</p> <p>The DON is responsible for attaining and sustaining compliance.</p> <p>The facility alleges compliance effective 11-16-18.</p>		