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F 000	INITIAL COMMENTS The follow citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 4/11/19.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility had a census of 93 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to administer medications in a manner according to the accepted standards of practice, for 2 of 2 residents. (#69, #19) Findings Included: - On 4/10/19 at 8:00 AM, observation revealed, in the Victoria Neighborhood dining room, 6 pills on a white napkin near Resident #69's plate. Licensed Staff G stood at the medication cart, 25 feet from the resident, providing instruction for the morning medication administration to (CMA) Certified Medication Aide students. The resident placed individual pills in his/her mouth between bites of food. Licensed Staff G continued to instruct CMA students as the resident self-administered medications. The Medical Record lacked documentation the staff assessed the resident for self-administration of medications.	F 658		

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

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The signed physician's orders, dated 3/6/19, lacked documentation of a medication self-administration order.

On 4/10/19 at 8:00 AM, Licensed Nurse G confirmed the resident had no medication self-administration order and stated the resident has never had trouble taking his/her medications.

On 4/10/19 at 8:05 AM, Licensed Nurse G followed the resident as he/she ambulated to the trash receptacle and asked to examine the napkin the resident had crumpled in his/her hand. Licensed Nurse G examined the napkin which contained no medications.

On 4/10/19 at 8:29 AM, Administrative Nurse D stated he/she expected staff to conform to the facility policy to observe the residents take their medications. Administrative Nurse D stated he/she expected the licensed staff, who instructed CMA students, to pay particular attention to follow standards of practice in instructing others.

The facility's Medication Administration policy, dated 2/2019, documented medications should be administered in a safe and timely manner, and as prescribed. The policy documented the resident would self-administer their own medications only if the attending physician, in conjunction with the nurse assessment, had determined the resident had the capacity to do so safely.

The facility failed to administer medications according to the accepted standards of practice for Resident #69, placing the resident at risk for

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medication errors.

- On 4/10/19 at 8:10 AM, observation revealed, in the Pfeifer Neighborhood dining room, a medication cup containing medications, near Resident #19's plate. Licensed Staff H stood at the medication cart, 25 feet from the resident, providing instruction for the morning medication administration to (CMA) Certified Medication Aide students. The resident placed individual pills in his/her mouth between bites of food. Licensed Staff H continued to instruct CMA students as the resident self-administered medications.

The Medical Record lacked documentation the staff assessed the resident for self-administration of medications.

The signed physician's orders, dated 3/6/19, lacked documentation of a medication self-administration order.

On 4/10/19 at 8:10 AM, Licensed Nurse H confirmed the resident had no medication self-administration order. Licensed Nurse H stated he/she had been trained by the previous nurse to leave Resident #19's medications in that manner.

On 4/10/19 at 8:29 AM, Administrative Nurse D stated he/she expected staff to conform to the facility policy to observe the residents take their medications. Administrative Nurse D stated he/she expected the licensed staff, who instructed CMA students, to pay particular attention to follow standards of practice in instructing others.

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F 658	Continued From page 3 The facility's Medication Administration policy, dated 2/2019, documented medications should be administered in a safe and timely manner, and as prescribed. The policy documented the resident would self-administer their own medications only if the attending physician, in conjunction with the nurse assessment, had determined the resident had the capacity to do so safely. The facility failed to administer medications according to the accepted standards of practice for Resident #19, placing the resident at risk for medication errors.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 93 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to meet the highest level of care for 1 of 1 resident reviewed for positioning. (#30) Findings Included: - The 3/6/19 physician's order sheet, documented the resident had diagnoses of muscle weakness,	F 684		

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inability to care for self, difficulty in walking, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), pneumonia (inflammation of the lungs), and heart failure.

The annual (MDS) Minimum Data Set assessment, dated 2/6/19, documented the resident had severe cognitive impairment, required extensive assistance of 1 to 2 staff members for (ADLs) Activities of Daily Living, and used a wheelchair for locomotion on and off the unit.

The ADL (CAA) Care Area Assessment, dated 2/6/19, did not trigger for ADLs.

The 4/7/19 care plan instructed staff to orient the resident to facility routine and activity schedule. The care plan directed the staff to meet the resident required assistance with ADL care, provide extensive assistance for hygiene, bed mobility, dressing, toilet use, and place the resident's extremities on the bed as needed.

The 3/14/19 at 3:00 PM, nurse's note documented the nurse received a fax from the resident's physician, which instructed the staff to elevate the resident's (BLE) Bilateral Lower Extremities as much as possible.

On 4/9/19 at 8:56 AM, observation revealed Direct Care Staff N and O transferred the resident from his/her wheelchair to the straight-backed chair located in his/her room, placed a pillow between the resident and the wooden arm of the chair for support, and the resident's call light within reach.

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On 4/9/19 at 9:19 AM, observation revealed the resident leaned toward the left side of the chair, the pillow displaced from his/her side, and the resident's shoulder rested against the wood arm rest.

On 4/9/19 at 9:51 AM, observation revealed Physician HH entered the resident's room with his/her assistant, closed the door for privacy, and exited 5 minutes later. Observation revealed the resident continued to lean to the left side of the straight-backed chair, with his/her left cheek and shoulder against the wood arm rest.

On 4/9/19 at 10:16 AM, observation revealed Direct Care Staff O entered the resident's room, replaced the water with a fresh pitcher, and exited the room.

On 4/9/19 at 10:40 AM, observation revealed a clergical visitor entered the resident's room, stated "he/she's asleep", anointed the resident, exited the room, and the resident remained in the same position.

On 4/9/19 at 11:10 AM, observation revealed Direct Care Staff N and Direct Care Staff O entered the room and the resident remained in the same position. Direct Care Staff N and Direct Care Staff O transferred him/her to a wheelchair for the noon meal.

On 4/10/19 at 12:08 PM, Administrative Nurse D stated staff members who observed the resident in the improper position, should have provided a change of position and pressure-relieving devices. Administrative Nurse D stated monthly unit meetings were held and he/she expected the staff to request a positioning evaluation and/or

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F 684	Continued From page 6 devices for the resident. On 4/10/19 at 2:31 PM, Physical Therapy Aide GG stated the staff in the therapy department would complete an evaluation for positioning needs upon request and provide recommendations for any resident in the facility. The facility's Repositioning policy, dated 12/17, documented guidelines were provided for the evaluation of resident's repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. The facility failed to meet the highest level of care for Resident #30, when staff failed to reposition the resident when observed in a compromised position, placing the resident at risk for decline in physical and mental well-being.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756		

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drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 93 residents. The sample included 19 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility's consultant pharmacist failed to identify and address with the physician and director of nursing, the failure to obtain blood laboratory tests per physician orders for Resident #46, failure to obtain an appropriate diagnosis for a scheduled antipsychotic medication (classes of medication used to treat psychosis and other mental emotional conditions) and the lack of a stop date for a (PRN) as needed, antipsychotic

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medication for Resident #43.

Findings included:

- Resident #46's physician order sheet, dated 3/6/19, documented a diagnosis of Type 2 Diabetes Mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) without complications.

The quarterly (MDS) Minimum Data Set assessment, dated 2/19/19, documented the resident had intact cognition with a (BIMS) Brief Interview for Mental Status score of 14, and was independent with mobility, transfers, and personal hygiene. The MDS documented the resident received insulin (a hormone produced in the pancreas which regulates the amount of glucose in the blood), antianxiety (medication for mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), antidepressant (medication for abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and diuretic (medication to promote the formation and excretion of urine) medications.

The annual MDS, dated 11/20/18, documented the same.

The 2/27/19 care plan documented the resident had diabetes, required insulin daily, and directed staff to administer the insulin per physician orders. The care plan directed staff to monitor labs as ordered and report the results to the physician.

The 6/28/18 physician orders directed staff to

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obtain a HgA1c (laboratory test which reflects average blood glucose levels over the past 3 months) blood test every 3 months for diabetes mellitus.

The medical record lacked documentation staff obtained the July and October 2018 HgA1c blood tests.

The 12/19/18 fax from the resident's primary care physician documented during rounds at the facility, he/she reviewed the resident's printed orders which included an order for staff to obtain a Hack blood test every 3 months. The fax documented the physician asked if he/she needed to write a different order to get the Hack blood test completed.

Review of the 8/7/18, 9/10/18, 10/9/18, 11/26/18, and 12/14/18 pharmacy consultant reviews revealed no documentation regarding the missing physician ordered HgA1c blood tests for July and October 2018.

On 4/9/19 at 8:24 AM, Medication Aide M entered Resident #46's room with his/her medications and asked the resident if it would be okay to check the resident's blood pressure. Medication Aide M checked the resident's blood pressure and then observed the resident swallow his/her medications.

On 4/10/19 at 9:56 AM, Administrative Nurse D verified staff had not obtained the July and October 2018 HgA1c blood tests.

On 4/10/19 at 11:08 AM, Administrative Nurse D verified the pharmacy consultant had not addressed the missing HgA1c blood test for

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Resident #46 in July and October 2018.

The facility's Laboratory, Radiology, and other Diagnostic Test Results policy, dated December 2017, documented signed and dated reports of all diagnostic services would be made a part of the resident's medical record.

The facility's Pharmacy Services - Role of the Provider Pharmacy policy, dated December 2017, documented the provider pharmacy would provide services that comply with applicable community policies and procedures; accepted professional standards of practice, and laws and regulations including (but not limited to) help the community identify needed supplies and services related to medications.

The facility's consultant pharmacist failed to identify and address with the physician and director of nursing, the failure to obtain the physician ordered HgA1c blood tests for Resident #46, which placed the resident at risk for blood sugar complications.
- Resident #43's physician order sheet, dated 3/12/19, documented the following diagnoses: acute respiratory failure with hypoxia (sudden severe difficulty breathing with low oxygen level), generalized muscle weakness, lack of coordination, abnormalities of gait (manner or style of walking) and mobility, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), dysphagia (difficulty swallowing), and dysarthria (difficulty speaking), following cerebrovascular disease (brain disorder).

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The admission (MDS) Minimum Data Set assessment, dated 1/24/19, recorded the resident had moderately impaired cognition with a (BIMS) Brief Interview for Mental Status score of 11. The MDS also recorded the resident required extensive assistance of 2 staff for bed mobility, transfers, walking, dressing, toilet use, and total assistance of 1 staff for eating. The MDS further recorded the resident received antipsychotic medication, antianxiety medication, and antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression) 7 days a week.

The 2/4/19 care plan recorded the resident received scheduled Seroquel (antipsychotic medication), Ativan (antianxiety medication), and (PRN) as needed Ativan. The care plan recorded these medications had (BBW) Black Box Warnings (strictest warning put in the labeling of prescription drugs about reasonable evidence of the association of a serious hazard with the drug). Seroquel for increased mortality in elderly residents with dementia, Ativan should be used at the lowest effective dose for the shortest possible time, and staff should monitor the resident closely for respiratory depression and sedation.

The 3/12/19 physician's order directed staff to administer Seroquel 50 (mg) milligrams, twice daily, and Seroquel 100 mg, at bedtime for depression.

The 3/12/19 physician's order directed staff to administer Ativan 0.5 mg, in the morning, Ativan 1 mg, at bedtime, and Ativan 0.5 mg, every 6 hours as needed for anxiety. Continued review of the order for PRN Ativan revealed no 14 day stop

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date.

The April 2019 (MAR) Medication Administration Record documented staff administered PRN Ativan 0.5 mg to the resident, for anxiety on 4/10/19. (81 days after the original physician's order)

The Pharmacy Consultant Reviews from 1/30/19, 2/20/19 and 3/27/19 lacked documentation of identifying the inappropriate diagnosis for the scheduled use of Seroquel and an appropriate stop date for the PRN Ativan.

On 4/4/19 at 10:49 AM, observation revealed the resident sat in a recliner in his/her room, alert, calm, and able to answer simple questions appropriately with moderate speech difficulty. The resident denied anxiety at the present time, but admitted he/she experienced anxiety particularly when alone and at night.

On 4/10/19 at 11:30 AM, Administrative Nurse D stated the Pharmacy Consultant Reviews lacked identification of an inappropriate diagnosis for the use of scheduled Seroquel and a stop date for the PRN Ativan order.

The facility's Psychotropic Medication policy, last revised 9/2018, documented that residents would only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. The policy further documented the specific duration of a psychotropic PRN order would be indicated in the order.

The facility's consultant pharmacist failed to ensure an appropriate diagnosis for Resident

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F 756	Continued From page 13 #43's use of the scheduled antipsychotic medication, Seroquel, and an appropriate stop date for the PRN antianxiety medication, Ativan, placing the resident at risk for adverse medication side effects.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 93 residents. The sample included 19 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure staff obtained blood laboratory test, per physician orders, for 1 of 5	F 757		

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sampled residents. (#46)

Findings included:

- Resident #46's physician order sheet, dated 3/6/19, documented a diagnosis of Type 2 Diabetes Mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) without complications.

The quarterly (MDS) Minimum Data Set assessment, dated 2/19/19, documented the resident had intact cognition with a (BIMS) Brief Interview for Mental Status score of 14, and was independent with mobility, transfers, and personal hygiene. The MDS documented the resident received insulin (a hormone produced in the pancreas which regulates the amount of glucose in the blood), antianxiety (medication for mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), antidepressant (medication for abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and diuretic (medication to promote the formation and excretion of urine) medications.

The annual MDS, dated 11/20/18, documented the same.

The 2/27/19 care plan documented the resident had diabetes, required insulin daily, and directed staff to administer the insulin per physician orders. The care plan directed staff to monitor labs as ordered and report the results to the physician.

The 6/28/18 physician orders directed staff to

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obtain a HgA1c (laboratory test which reflects average blood glucose levels over the past 3 months) blood test every 3 months for diabetes mellitus.

The medical record lacked documentation staff obtained the July and October 2018 Hack blood tests.

The 12/19/18 fax from the resident's primary care physician documented during rounds at the facility, he/she reviewed the resident's printed orders which included an order for staff to obtain a HgA1c blood test every 3 months. The fax documented the physician asked if he/she needed to write a different order to get the Hack blood test completed.

On 4/9/19 at 8:24 AM, Medication Aide M entered Resident #46's room with his/her medications and asked the resident if it would be okay to check the resident's blood pressure. Medication Aide M checked the resident's blood pressure and then observed the resident swallow his/her medications.

On 4/10/19 at 9:56 AM, Administrative Nurse D verified staff had not obtained the July and October 2018 HgA1c blood tests.

The facility's Laboratory, Radiology, and other Diagnostic Test Results policy, dated December 2017, documented signed and dated reports of all diagnostic services would be made a part of the resident's medical record.

The facility failed to ensure staff obtained physician ordered HgA1c blood tests every 3 months for Resident #46, which placed the

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F 757	Continued From page 16 resident at risk for blood sugar complications.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		

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§483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 93 residents. The sample included 19 residents, of which 5 were reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure an appropriate diagnosis for a scheduled antipsychotic medication (class of medication used to treat psychosis (impairment of reality) and other mental or emotional conditions) and an appropriate stop date for a (PRN) as needed, antianxiety medication (class of medications that calm and relax people with excessive anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), nervousness, or tension) for 1 of 5 sampled residents. (#43)

Findings included:

- Resident #43's physician order sheet, dated 3/12/19, documented the following diagnoses: acute respiratory failure with hypoxia (sudden severe difficulty breathing with low oxygen level), generalized muscle weakness, lack of coordination, abnormalities of gait (manner or style of walking) and mobility, anxiety (mental or

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emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), dysphagia (difficulty swallowing), and dysarthria (difficulty speaking), following cerebrovascular disease (brain disorder).

The admission (MDS) Minimum Data Set assessment, dated 1/24/19, recorded the resident had moderately impaired cognition with a (BIMS) Brief Interview for Mental Status score of 11. The MDS also recorded the resident required extensive assistance of 2 staff for bed mobility, transfers, walking, dressing, toilet use, and total assistance of 1 staff for eating. The MDS further recorded the resident received antipsychotic medication, antianxiety medication, and antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression) 7 days a week.

The 2/4/19 care plan recorded the resident received scheduled Seroquel (antipsychotic medication), Ativan (antianxiety medication), and (PRN) as needed Ativan. The care plan recorded these medications had (BBW) Black Box Warnings (strictest warning put in the labeling of prescription drugs about reasonable evidence of the association of a serious hazard with the drug). Seroquel for increased mortality in elderly residents with dementia, Ativan should be used at the lowest effective dose for the shortest possible time, and staff should monitor the resident closely for respiratory depression and sedation.

The 3/12/19 physician's order directed staff to administer Seroquel 50 (mg) milligrams, twice

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daily, and Seroquel 100 mg, at bedtime for depression.

The 3/12/19 physician's order directed staff to administer Ativan 0.5 mg, in the morning, Ativan 1 mg, at bedtime, and Ativan 0.5 mg, every 6 hours as needed for anxiety. Continued review of the order for PRN Ativan revealed no 14 day stop date.

The April 2019 (MAR) Medication Administration Record documented staff administered PRN Ativan 0.5 mg to the resident, for anxiety on 4/10/19. (81 days after the original physician's order)

On 4/4/19 at 10:49 AM, observation revealed the resident sat in a recliner in his/her room, alert, calm, and able to answer simple questions appropriately with moderate speech difficulty. The resident denied anxiety at the present time, but admitted he/she experienced anxiety particularly when alone and at night.

On 4/10/19 at 11:30 AM, Administrative Nurse D stated the resident's medical record documented an inappropriate diagnosis for the use of scheduled Seroquel. Administrative Nurse D also stated the resident's PRN Ativan order lacked a stop date.

The facility's Psychotropic Medication policy, last revised 9/2018, documented that residents would only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. The policy further documented the specific duration of a psychotropic PRN order would be indicated in the order.

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F 758	Continued From page 20 The facility failed to ensure an appropriate diagnosis for Resident #43's use of the scheduled antipsychotic medication, Seroquel, and an appropriate stop date for the PRN antianxiety medication, Ativan, placing the resident at risk for adverse medication side effects.	F 758		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 93 residents. The	F 761		

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sample included 19 residents. Based on observation, record review, and interview the facility failed to secure and return 1 of 1 an expired emergency kit after use.

Findings included:

- On 4/4/19 at 8:05 AM, during the initial tour, observation revealed in the Victoria household medication room, an unsecured emergency medication kit opened, with a tag on the side which documented the kit expired on 3/2019.

On 4/4/19 at 8:05 AM, Nurse I verified the above finding.

On 4/8/19 at 10:34 AM, Administrative Nurse D verified the emergency medication kit in the Victoria household medication room was expired, and not secured. Video observation revealed a nurse had opened the kit on 4/3/19 at 8:53 PM, but failed to note the kit expired or re-secure it with a new break away lock. Administrative Nurse D stated staff should re-secure the kit with a break away lock after use.

The facility ' S 12/2017 Emergency Medication Kit policy documented each community will store an emergency medication kit in the medication room. The kit is supplied with a break away lock to identify when the kit is opened and used. The policy documented the consultant pharmacist shall inspect the emergency medication kits monthly and record the findings on the record maintained with each kit.

The facility failed to return and secure an expired emergency medication kit, placing residents at risk for receiving ineffective medications.

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