**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:**
GLEN OAKS HEALTH AND REHABILITATION

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
1101 GLEN OAKS ROAD
SHELBYVILLE, TN 37160

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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| F 431     | SS=D| **(e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS**

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was noted that:

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| F 431     |     | 1. a) On 12/13/10, the DON removed Risperidon 0.5 mg packets from the locked medication cart educating Nurse #1 to the concern.
          |     | b) On 12/13/10, the DON conducted a facility wide audit of medication carts to ensure medication storage compliance.
          |     | 2. All residents within the facility have the potential to be affected.
          |     | 3. a) On 12/13/10, Nurse #1 was individually re-educated by the DON regarding the proper storage of medications.
          |     | b) On 12/20/10, facility Medication Managers were re-educated by the DON regarding the proper storage of medications.
          |     | c) Weekly random medication cart audits will be conducted by the Administrator, DON and/or Designee to ensure continued compliance.
          |     | 4. Random medication cart audits will be conducted by the Administrator, DON and/or Designee with findings reported monthly to the QA/1 Committee until resolved.
          |     | 12/30/10 |

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.

LAW Lab Director or Provider/Supplier Representative's Signature:

*Jeff Richardson*

Title: Administrator

Date: 12/20/10

**Event ID:** TQS/0111

**Facility ID:** TN0202

**If continuation sheet Page:** 1 of 2

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**RECEIVED**

**FORM APPROVED**
**OMB NO. 0938-0391**

**PRINTED:** 12/18/2010
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<td>F 431</td>
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<td>Continued From page 1 determined the facility failed to ensure that medications were stored securely in 1 of 6 (200 hall medication cart) medication storage areas.</td>
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<td>The findings included:</td>
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<td>Observations and an interview on the 200 hall outside room A37 on 12/13/10 at 4:45 PM, revealed a packet of Risperidone 0.5 milligrams (mg) was sticking out of the locked medication cart. The surveyor pulled on the packet of Risperidone and three more packets of Risperidone 0.5 mg came out. The Director of Nursing (DON) came down the hall and the Risperidone was shown to her. The DON proceeded to pull out all of the Risperidone packages and waited for the nurse to return to the cart. At 4:48 PM, Nurse #1 returned to the medication cart and the Director of Nursing showed Nurse #1 the packages of Risperidone. Nurse #1 stated, &quot;Was it [Risperidone] sticking out?&quot;</td>
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