## Summary Statement of Deficiencies

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<tr>
<th>ID</th>
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<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>F 280</td>
<td>SS-D</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to revise the current care plan for fall mats, protective head gear and a bolster cushion for 1 of 19 (Resident #7) sampled residents.

The findings included:

- Medical record review for Resident #7 documented an admission date of 12/18/08 and a readmission date of 12/24/10 with diagnoses of Post Traumatic Brain Injury, Lung Cancer with Metastasis to the Neck, Seizure Disorder and

Corrective Action:

1. Resident #7 care plan was reviewed and updated by the MDS Coordinator to reflect the use of fall mats, protective head gear and bolster cushions on 3/22/2011.
2. The MDS Coordinators on 4/7/2011 and 4/8/2011 audited care plans to ensure the accuracy of coding fall mats; protective head gear; and bolster cushions.

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**LABORATORY DIRECTORS OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE**

[Signature]

**TITLE**

[Title]

**DATE**

[Date]
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 280</td>
<td>Continued From page 1 Hypertension. Review of the comprehensive care plan dated 1/26/11 did not include the interventions of fall mats, protective head gear and bolster cushion. Observations in Resident #7's room on 3/21/11 at 1:45 PM and 4:06 PM and on 3/22/11 at 7:20 AM, 10:00 AM, 12:15 PM and 2:43 PM, revealed Resident #7 lying in bed with protective head gear on his head, fall mats on each side of his bed and a bolster cushion under him. During an interview in the Minimum Data Set (MDS) Nurse #2's office on 3/22/11 at 4:55 PM, the MDS Nurse #2 was asked about the protective head gear, fall mats and bolster cushion not being on the current care plan. The MDS Nurse #2 stated, &quot;...It just didn't get [the interventions] carried over...&quot;</td>
<td>F 280</td>
<td>3. The MDS Coordinators were in serviced by the DON on 3/25/2011 to ensure that the care plan accurately reflects the resident's intervention and current status. 4. The DON, Unit ADONs and/or MDS Coordinators will monitor for compliance through monthly chart audits for three months and report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Unit Assistant Directors of Nursing, MDS Coordinators, Medical Records, Staffing Coordinator, Bookkeeper, Food Service Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the team will re-in service the MDS Coordinators and will continue monitoring until substantial compliance is achieved. Different members of the committee will participate depending on the nature of the audit. Completion Date: 4/14/2011</td>
<td>4/14/2011</td>
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<td>F 282</td>
<td>493.20(k)3(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, it was determined that the facility failed to follow the intervention on the care plan for a lift wheelchair when out of bed for 1 of 15 (Resident #6) observed sampled residents. The findings included: Medical record review for Resident #6</td>
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**Note:** The provided text represents a snapshot of the document's content. For a full understanding, it is recommended to review the entire document.
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<td>During an interview in the Minimum Data Set (MDS) Nurse #2's office on 3/22/11 at 4:55 PM, the MDS Nurse #2 was asked about the protective head gear, fall mats and bolster cushion not being on the current care plan. The MDS Nurse #2 stated: &quot;...It just didn't get [the interventions] carried over...&quot;</td>
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<td>F 282</td>
<td>Continued From page 2</td>
<td>Documented an admission date of 1/24/11 with diagnoses of Dementia, Chronic Renal Failure, Percutaneous Endoscopic Gastrostomy Tube Placement, Diabetes Mellitus, Congestive Heart Failure, Glaucoma, Malnutrition, Aspiration, and Coronary Artery Disease. Review of the comprehensive care plan dated 2/2/11 and revised 2/18/11 documented, &quot;...up to lift wc [wheelchair] daily...&quot;</td>
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<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</td>
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This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, and interview, it was determined the facility failed to ensure pre and post dialysis weights were documented as per policy for 2 of 19 (Residents #12 and #13) sampled residents and failed to ensure physician’s orders were followed for accuchecks for 1 of 19 (Residents #18) sampled.
F 282

Continued From: page 2
documented an admission date of 1/24/11 with
diagnoses of Dementia, Chronic Renal Failure,
Peritoneal Endoscopy Gastrostomy Tube
Placement, Diabetes Mellitus, Congestive Heart
Failure, Glaucoma, Malnutrition, Aspiration, and
Coronary Artery Disease. Review of the
care plan dated 2/2/11 and
revised 2/15/11 documented, "...up to tilt w/c
[wheelchair] daily..."

Observations in Resident #6's room on 3/21/11 at
10:25 AM, revealed Resident #6 sitting up in her
wheelchair. The wheelchair was not tilted.

During an interview in Resident #6's room on
3/23/11 at 7:35 AM, the Director of Nursing
confirmed that the wheelchair in Resident #6's
room did not tilt.

F 309

483.25 PROVIDE CARE/SERVICES FOR
HIGHEST WELL BEING

Each resident must receive and the facility must
provide the necessary care and services to attain
or maintain the highest practicable physical,
mental, and psychosocial well-being, in
accordance with the comprehensive assessment
and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review,
and interview, it was determined the facility failed
to ensure pre and post diaylsis weights were
documented as per policy for 2 of 19 (Residents
#12 and #13) sampled residents and failed to
ensure physician's orders were followed for
accucheks for 1 of 19 (Residents #18) sampled
Continued from page 3
residents.

The findings included:

1. Review of the facility's "Dialysis Patient Services" policy documented, "...E. Nursing documentation required: Pre and Post dialysis weights..."

a. Medical record review for Resident #12 documented an admission date of 1/7/11 with diagnoses of End Stage Renal Disease, Diabetes Mellitus Type II, and Severe Hypertension. Review of the Medication Administration Record (MAR) documented no pre and post weights for March 2011.

During an interview in the Director of Nursing's (DON) office on 3/23/11 at 9:25 AM, the DON was asked about the documentation of pre and post dialysis weights. The DON stated, "...it should be on the MAR..."

b. Medical record review for Resident #13 documented an admission date of 1/31/11 with diagnoses of End Stage Renal Disease, Diabetes Mellitus Type II, and Severe Hypertension. Review of the MAR documented no pre and post weights for March 2011.

During an interview in the skilled nursing charting room on 3/23/11 at 8:50 AM, Nurse #10 stated, "...the policy for weights for dialysis should be... weighed pre and post dialysis and recorded..."

During an interview in the 300 hallway on 3/23/11 at 9:30 AM, the Senior Nurse Consultant confirmed the pre and post dialysis weights for Residents #12 and 13 were not documented on...
F 309 Continued From page 4 the MAR.

2. Medical record review for Resident #18 documented an admission date of 9/27/10 with diagnoses of Sepsis, Urinary Tract Infection, Pneumonia, Peripheral Vascular Disease, Respiratory Failure, Hypertension, Diabetes, and Tracheostomy. Review of a physician's order dated 9/27/10 documented, "...Accu [sign of check mark] [accucheck] qid [four times a day]..." Review of the routine medications MAR for September 2010 documented a sliding scale for Insulin and the time of 8:30 AM under which was written, "Result [of accucheck], Amount [of Insulin], Site [of injection]..." Review of the routine medications MAR for October 2010 documented a sliding scale for Insulin and the time of 6:30 AM under which was written, "Result [of accucheck], Amount [of Insulin], Site [of injection],..." The facility was unable to provide documentation of accuchecks being performed qid as ordered.

F 322 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a nasso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and naso-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure 1 of 3 (Nurse #3) nurses...
Continued From page 5
provided care and services appropriately during the administration of medications to Random Resident (RR #2) with a Percutaneous Endoscopy Gastrostomy (PEG) Tube.

The findings included:

Review of the facility’s enteral tube management/medication administration policy documented, "Prepare...medication as ordered...Crush pill (if crushable), and mix with fluid to make a thin solution with small sediment. Mix...with water or saline..."

Medical record review for RR #2 documented an admission date of 11/22/10 with diagnoses of Acquired Brain Injury, Tracheal Stenosis, and Urinary Tract Infection. Review of the physician’s orders dated 1/30/11 documented, “…CALCIUM 600W [with] / D 600-400 [600 milligrams (mg) of Calcium and 400 mg of Vitamin D] PPT [per PEG tube] ONE THREE TIMES DAILY,...HYDRAZINE TAB (tablet) 50 MG TAKE ONE TAB PER PEG TUBE THREE TIMES DAILY, HYDRAZINE HCL [hydrochloride] -25MG-TABS ONE PPT THREE TIMES DAILY (WITH 50 MG)."

Observation in RR #2’s room on 3/21/11 at 4:50 PM, Nurse #3 crushed Calcium W/D and Hydrazine separately, poured 10 cubic centimeters (cc) of water into the medication administration syringe, then poured the crushed medications into the syringe. The medication did not flow into the PEG tube. Nurse #3 disconnected and shook the syringe to mix the medication and then administered it into the PEG tube.

Corrective Action:
1. Nurse #3 was in serviced by the DON on 3/24/2011 regarding the proper administration of medications per PEG.
2. Facility rounds were made by the DON and/or Unit ADONs on 3/24/2011 to ensure that Licensed Nurses were allowing for medications to dissolve before administering the medication into the PEG tube.
3. The Licensed Staff was in-serviced on 3/24/2011 and 3/31/2011 by the DON regarding the proper administration of medications for Residents’ with PEG tubes.
4. DON, Unit ADONs, and/or MDS Coordinator will monitor for compliance through med pass audits weekly for one month, then monthly for three months. Audit findings will be reported to the QA committee, consisting of the Medical Director, Administrator, Director of Nursing, Unit Assistant Directors of Nursing, MDS Coordinators, Medical Records, Staffing Coordinator, Bookkeeper, Food Service Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the team will re-in service the Licensed Nurses and will continue monitoring until substantial compliance is achieved.

Completion Date: 4/14/2011
Continued From page 6
During an interview in the Director of Nursing's (DON) office on 3/23/11 at 8:40 AM, the DON stated, "...should dissolve meds [medications] after crushing." F 322

F 322
483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on police review, medical record review, observations and interviews, it was determined the facility failed to ensure 5 of 8 (Nurses #1, 2, 4, 6 and 9) medication nurses administered medications with a medication error rate of less than 5 percent (%). A total of 5 medication errors were observed out of 41 opportunities for error, resulting in a medication error rate of 12.19%.

The findings included:
1. Review of the facility's "INSULIN ADMINISTRATION IN RELATION TO MEAL SERVICE" policy documented, "Some insulins have rapid onset times of action, requiring timely meal/food intake to avoid hypoglycemic reactions. Each change nurse's assigned med [medication] pass must be evaluated to determine if meal delivery times should be staggered to coincide with the administration of insulin. The most common insulins, along with their onset times, are listed below: Humulin R [Regular] -30 min. [minutes], Novolin R-30 min..." a. Medical record review for Resident #2

F 332
483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

SS=E

Requirement:
The facility will ensure that it is free of medication error rates of five percent or greater.

Corrective Action:
1. For Resident #2; Random Resident #1, Random #4; and Random Resident #5: physician was notified of medication errors and no adverse reactions were noted. Random Resident #3en 3/23/2011 physician orders were obtained for Miralax.
2. Audits were completed by the DON mid/Unit ADONs on 4/7/2011 to ensure that the administration of insulin/medication coincides with meal delivery times; correct dosage of insulin is given; that medications given have the proper signed physician orders; and that the proper medication dosage is given.
3. The Licensed Nurses were in serviced 3/24/2011 and 3/31/2011 by the DON on medication administration with emphasis on proper dosage of medications; coinciding insulin/medication with meals when indicated; and to have signed physician orders for all medications given.
Continued From page 7

documented an admission date of 1/15/10 with diagnoses of Presentile Depression, Dementia without Behaviors and Diabetes Mellitus. Review of a physician’s order dated 3/14/11 documented, "...HUMULIN R INSULIN-100UNITS/ML [millimeter]
FINGERSTICK BLOOD GLUCOSE TWICE EVERY DAY WITH SLIDING SCALE-200- [to] 300= [amount of insulin to be administered] 4 UNITS; 301-400=8 UNITS..."

Observations in Resident #2’s room on 3/21/11 at 4:06 PM, revealed Nurse #1 administered 4 units of Humulin R Insulin to Resident #2 for a blood sugar of 305. Resident #2 did not receive her supper until 5:30 PM. The administration of the insulin more than 30 minutes before Resident #2 received her meal and the failure to administer the correct dosage of (6 units) insulin resulted in medication error #1.

b. Medical record review for RR #1 documented an admission date of 1/15/10 with diagnoses of Hypertension, Congestive Heart Failure and Diabetes Mellitus. Review of a physician’s order dated 2/9/11 documented, "NOVOLIN R INSULIN 100UNITS/ML FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME WSLIDING SCALE 251-300=8 UNITS..."

Observations in RR #1’s room on 3/21/11 at 4:30 PM, Nurse #2 administered 8 units of Novolin R insulin to RR #1. RR #1 did not receive his supper meal until 5:30 PM. The administration of the Novolin insulin more than 30 minutes before RR #1 received his supper meal resulted in medication error #2.

During an Interview in the Director of Nursing’s DON office on 3/23/11 at 8:40 AM, the DON...
Continued From page 8

was asked what her expectations were related to insulin administration and meals. The DCN stated, "Follow manufacturer's guidelines. VWouldn't expect to give more than 30 minutes before meals..."

2. Review of the facility's "Medications" policy documented, "...All orders for drugs must be signed by the physician..."

Medical record review for RR #3 documented an admission date of 8/30/10 with diagnoses of Cardiac Arrhythmia, Seizure and Hypertension. Review of the physician's orders dated 2/14/11 revealed no documentation of an order for Miralax.

Observations in RR #3's room on 3/22/11 at 7:10 AM, revealed Nurse #4 administered Miralax 17 grams in six ounces of water to RR #3. The administration of the Miralax without a signed physician's order resulted in medication error #3.

During an interview in the skilled nursing hall charting room on 3/23/11 at 7:55 AM, Nurse #4 confirmed there wasn't a current signed order for the Miralax.

3. Review of the facility's "Medications" policy documented, "...administration of medications ...3. Right Dose..."

F 332  Continued From page 9
Observations in RR #4’s room on 3/22/11 at 8:25 AM, Nurse #6 administered one 75 mg tablet of Lyrica to RR #4. The failure to administered two 75 mg tablets of Lyrica to RR #4, as ordered resulted in medication error #4.

During an interview on the 300 hall on 3/23/11 at 8:10 AM, Nurse #6 stated, "I should have given two [referring to the Lyrica]."

4. Review of the facility’s "Medications" policy documented, "...administration of medications...Route 5. Right Time/Frequency...With meals usually means medications are given during meals or up to 30 minutes after the meal is eaten..."

Medical record review for RR #5 documented an admission date of 9/2/08 with diagnoses of Hypertension, Congestive Heart Failure and Diabetes Mellitus. Review of a physician’s order dated 2/2/11 documented, "...Oxcar [Oscal] 500mg [plus] D [vitamin] 1 po TID [three times daily] c [with] meals..."

Observations in RR #5’s room on 3/22/11 at 11:38 AM, revealed Nurse #9 administered Oxcar 500mg + D to RR #5. The failure to administer the medication with a meal resulted in medication error #5.

F 333  483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

F 333  483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS
SS=D

Requirement: The facility will ensure that residents are free of any significant medication errors.
F.333 Continued From page 10

Based on review of the "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacist, policy review, medical record review, observation, and interview, it was determined 2 of 8 medication nurses (Nurse #1 and #2) failed to administer medications without significant medication errors.

The findings included:

1. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulins related to meals documented, "...Humulin R [Regular] / Novolin R ONSET [in hours, unless noted] ...0.5 - [to]1 ...TYPICAL DOSING/COMMENTS... 30 minutes before meals..."

2. Review of the facility's "INSULIN ADMINISTRATION IN RELATION TO MEAL SERVICE" policy documented, "Some insulins have rapid onset times of action, requiring timely meal/food intake to avoid hypoglycemic reactions. Each charge nurse's assigned meal [medication] pass must be evaluated to determine if meal delivery times should be staggered to coincide with the administration of insulin. The most common insulins, along with their onset times, are listed below: Humulin R-30 min. [minutes], Novolin R-30 min..."

3. Medical record review for Resident #2 documented an admission date of 1/15/10 with diagnoses of Presenile Depression, Dementia without Behaviors and Diabetes Mellitus. Review of a physician's order dated 3/14/11 documented, "...HUMULIN R INSULIN-100UNITS/ML [milliliters]..."
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<td>F 333</td>
<td>Continued From page 11 FINGERSTICK BLOOD GLUCOSE TWICE EVERY DAY W/SLIDING SCALE—200 [to] 300 [amount of insulin to be administered] 4 UNITS, 301-400=8 UNITS...</td>
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<td>Observations in Resident #2's room on 3/21/11 at 4:05 PM, revealed Nurse #4 administered 4 units of Humulin R Insulin to Resident #2 for a blood suger of 305. Resident #2 did not receive her supper until 5:30 PM. The administration of the insulin more than 30 minutes before Resident #2 received her meal and the failure to administer the correct dosage of (8 units) insulin resulted in a significant medication error.</td>
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<td>4. Medical record review for Random Resident (RR) #1 documented an admission date of 4/1/10 with diagnosis of Hypertension, Congestive Heart Failure and Diabetes Mellitus. Review of a physician's order dated 2/9/11 documented, &quot;...NOVOLIN R INSULIN 100 UNITS/ML FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME W/SLIDING SCALE .251-300=8 UNITS...&quot;</td>
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<td>Observations in RR #1's room on 3/21/11 at 4:30 PM, Nurse #2 administered 8 units of Novolin R insulin to RR #1. RR #1 did not receive his supper meal until 5:30 PM. The administration of the Novolin insulin more than 30 minutes before RR #1 received his supper meal resulted in a significant medication error.</td>
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|                  | During an interview in the Director of Nursing's (DON) office on 3/23/11 at 8:40 AM, the DON was asked what her expectations were related to insulin administration and meals. The DON stated, "Follow manufacturer's guidelines. Wouldn't expect to give more than 30 minutes
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<td>F 431</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
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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 1970 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.

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**Statement of Deficiencies and Plan of Correction**

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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
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<td>F 481</td>
<td>Continued From page 13</td>
<td>Based on policy review, observation and interview, it was determined the facility failed to ensure medications were stored in locked compartments on 1 of 8 (700 hall) halls, failed to ensure medications were stored securely in 1 of 8 (600 hall medication cart) medication storage areas and failed to ensure internal and external medications were not stored together in 1 of 8 (300 hall medication cart) medication storage areas. The findings included: 1. Review of the facility's &quot;MEDICATION STORAGE&quot; policy documented, &quot;...Medications must be properly stored in medication rooms or medication carts and must be securely locked...&quot; Observations of the 700 hall on 3/21/11 at 10:15 AM, revealed a plastic medication cup with a white creamy substance in the cup on the bedside table in room 712. Observations of the 700 hall on 3/21/11 at 10:27 AM, revealed a plastic medication cup with a creamy white substance in the cup on the overbed table in room 715. Observations of the 700 hall on 3/21/11 at 10:30 AM, revealed an icy Hot stick, Turn, and Bio-Ice pain gel on the bedside table in room 709. 2. Review of the facility's &quot;MEDICATION STORAGE&quot; policy documented, &quot;...Medications must be properly stored in medication rooms or medication carts and must be securely locked when not in use...&quot;</td>
<td>F 481</td>
<td>The facility will 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. Corrective Action: 1. a) On 3/21/2011 and 3/23/2011 the medication cups that had a creamy white substance found in room 712 and 715; and the icy hot, Turn, and bio-ice pain gel found in room 709 were removed from the rooms and immediately discarded. b) On 3/22/2011 the 600 hall medication cart was immediately locked by the Charge Nurse Assigned to the cart. c) On 3/23/2011 the external medications of Hydrocortisone Ointment, Zinc Oxide, and Methyl salicylate powder were removed from the drawer that also had internal medications by the Charge Nurse assigned to the cart. 2. The DON and/or Unit ADONs on 3/23/2011 completed a med cart audit to ensure that the carts were locked and that external and internal medications were found in separate drawers; a room audit was also completed on 3/23/2011 by the Unit ADONs to ensure that there are no unattended medications/creams left in the resident's rooms.</td>
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**HARBOR VIEW NURSING AND REHABILITATION CENTER, INC**

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<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F431</td>
<td>Continued From page 14 Observations of the 500 hall on 3/22/11 at 11:10 AM revealed the 500 hall medication cart was unlocked, unattended and out of the nurse's view. During an interview on the 500 hall on 3/22/11 at 11:15 AM, Nurse #8 verified that the 500 hall medication cart was unlocked. 3. Review of the facility's &quot;MEDICATION STORAGE&quot; policy documented, &quot;...All internal and external medications and preparations must be stored in separate trays, drawers, compartments or containers...&quot; Observations of the 300 hall medication cart on 3/23/11 at 10:02 AM revealed internal medications were stored together with external medications. The external medications were as follows: a. Hydrophor Ointment. b. Zinc Oxide. c. Nystatin topical powder. The Internal medications were as follows: a. Geri-Lanta. b. Ferrous Sulfate elixir. c. Milk of Magnesia. d. Q-Dry tablets. e. Geri-Tonic. f. Gualenesin DM. g. Docusate Sodium liquid. h. Sodium Polystyrene syrup. i. Unjyry Protein Powder. During an interview on the 300 hall on 3/23/11 at 10:15 AM, Nurse #8 confirmed that the internal and external medications were stored together.</td>
<td>F431</td>
<td>3. The Licensed Nurses were in service 3/24/2011 and 3/31/2011 by the DON on medication storage including locking of medication cart; removing and discarding unattended medication/creams from resident's rooms; and separating the external medications from the internal medications. 4. DON, Unit ADONs, and/or MDS Coordinator will monitor for compliance through med cart/room audits weekly for one month, then monthly for three months. Audit findings will be reported to the QA committee consisting of the Medical Director, Administrator, Director of Nursing, Unit Assistant Directors of Nursing, MDS Coordinators, Medical Records, Staffing Coordinator, Bookkeeper, Food Service Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the team will re-in service the Licensed Nurses and will continue monitoring until substantial compliance is achieved. Different members of the committee will participate depending on the nature of the audit.</td>
<td>4/14/2011</td>
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**RECEIVED APR 11 2011**