MEDICATION CARTS WILL BE SECURED/LOCKED WHEN OUT-OF-SIGHT OF THE NURSE ADMINISTRATION MEDICATIONS.

Nurse #1 received 1 on 1 written counseling and re-education of the necessity of following established procedures during medication pass. This counseling was performed by the Director of Nursing on 12/22/11.

To identify and prevent a re-occurrence of similar situation, mandatory in-services for all nurses were given on, 12/27, & 12/28 on the topic of Medication Administration and Storage by the Director of Nurses. Pre-and post test were given to measure effectiveness of inservice.

Unannounced, med-pass observations will be conducted by the Director of Nursing on a weekly basis for the next three months and Pharmacy Consultant will conduct med-pass observations on a monthly basis to assure continued compliance of properly locking the medication carts. New hires will review Medication Administration and Storage policies and procedures as part of orientation by the Staff Development Coordinator.
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Observations on A hall on 12/19/11 at 1:50 PM. Nurse #1 pulled medications from the medication cart, knocked on a residents door and entered the room. Nurse #1 left the medication cart unlocked and out of her sight while in a resident's room.

During an interview in the conference room on 12/20/11 at 10:00 AM, the Director of Nursing stated, "If the nurse goes into a room, turns her back, or is away from the cart she should lock it [medication cart]."

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Results of the med pass observations review will be presented to the Continual Quality Improvement (CQI) Committee comprised of the Medical Director, the Administrator, the Director of Nursing, the Staff Development Coordinator, the Pharmacy Consultant, Risk Manager, and Restorative Nurse, Social Worker, Activity Director, and Dietary Manager at it's monthly meeting and will be monitored for continued compliance.