STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 11/12/13 and completed on 11/14/13, the sample included two (2) residents for complete review, nine (9) residents for focused review, and one (1) closed record fore review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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 observation, record review, and staff interview, the facility failed to review and revise	F 280	**F-280:** Maryhill Manor is committed to the development and implementation of a comprehensive plan of care that reflects the residents ever-changing needs. To that end, Maryhill Manor will do the following to enhance our services: 1. Actions for the resident identified: Resident #8 – specifics related to this residents behaviors and Haldol use were added to the care plan. 2. The care plans of all residents who receive an antianxiety and/or antipsychotic medication will be reviewed for completeness and accuracy by the MDS nurses. 3. The facility policy on psychotropic drug use will be revised to include the need to address the reason for the medication's use in the care plan, along with nonpharmacological approaches to these needs. Nurses were educated on the policy changes 12/17/13. Continued on next page	12-19-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Fandrem | TITLE: Administrator/CEO | (X6) DATE: 12/13/13

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 280	Continued From page 1 the comprehensive care plan to reflect the resident's status for 1 of 7 sampled residents (Resident #8) on an antianxiety and/or antipsychotic medication. Failure to review and revise the plan of care limited the facility staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #8's medical record occurred on all days of survey. Medical diagnoses included anoxic brain damage, depression, and anxiety. A physician's progress note, dated 01/22/13, stated, ". . . Initiated Haldol 0.5 mg [milligrams] BID [twice a day] for obsessions and agitation and sexual behaviors to staff . . ." Haldol is an antipsychotic medication. Resident #8's care plan failed to identify problems related to obsessions, agitation, sexual behaviors, and the use of an antipsychotic medication. During an interview on morning of 11/14/13, an administrative nurse (#1) agreed Resident #8's care plan lacked problems and interventions related to daily Haldol.	F 280	Continued from previous page 4. A Quality Assurance check will be completed by a nurse under the direction of the Nursing Services Coordinator monthly for the next three months, and quarterly for a minimum of one year. The QA check will monitor the following: i. Is the need and reason for antipsychotic drug use addressed in the care plan? ii. Are nonpharmacological approaches also included in the care plan?	
F 309 SS=D	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.	F 309	**F-309:** Maryhill Manor is committed to providing services to help residents attain or maintain their highest practicable physical, mental, and psychosocial well-being. To that end, we will do the following to enhance the services we provide: Continued on next page	12-19-13

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F 309	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia (BPSD) for 2 of 4 sampled residents (Residents #1 and #7) identified with behaviors and receiving as needed (PRN) medications. Failure to thoroughly assess the residents' behaviors, implement individualized interventions, including non-pharmacological interventions, and establish on-going monitoring of the behaviors may result in decreased physical, mental, and psychosocial well-being and may negatively impact the residents' quality of life. Findings include: Review of the facility policy titled "PSYCHOTROPIC MEDICATION POLICY" occurred on 11/14/13. This policy, dated September 2013, stated, ". . . 4. Our goal is to determine the underlying cause of behavioral symptoms so that the appropriate treatment of environmental or medical interventions can be utilized prior to psychopharmacologic medication use. . . . Procedure: 1. Orders for psychotropic medication are indicated only for the treatment of specific medical and or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non pharmacologic approaches. . . . 5. Nursing will document on any behaviors presented by the resident and behavioral care plans may be developed. . . ."	F 309	1. Resident #1 and #7: The care plan was reviewed to ensure it includes a thorough assessment of the residents' behaviors and individualized interventions. 2. All residents with behavioral and psychological symptoms of dementia will be reviewed by the MDS nurses to ensure that their behaviors have been thoroughly assessed and that their care plan includes individualized interventions, including non-pharmacological interventions. 3. The use of PRN psychotropic medications will be addressed in the Psychotropic Medication policy and will include a guideline of how often a psychotropic PRN can be used before approaching the physician for a regularly scheduled medication. The policy will also include guidelines for use of non-pharmacological approaches prior to the administration of medications. Nurses will be instructed in the documentation of non-pharmacological approaches prior to the administration of prn medications for behavior on 12/17/13. 4. A Quality Assurance check will be completed by a nurse under the direction of the Nursing Services Coordinator monthly for the next three months, and quarterly for a minimum of one year. The QA check will monitor the following: a. Are non-pharmacological approaches included in the care plan? b. Have non-pharmacological approaches been tried and documented prior to the administration of prn medications?	

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F 309	Continued From page 3 - Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease and unspecified psychosis. The resident's admission Minimum Data Set (MDS), dated 08/28/13, identified both long and short term memory problems, delusional thoughts, delirium, physical and verbal behaviors, rejection of cares, and wandering. Resident #7's medication regimen included: *Ativan (an antianxiety medication) 0.5 milligrams (mg) three times a day (TID) PRN, initiated on 08/25/13 and discontinued on 09/04/13 * Haldol (an antipsychotic medication) 2.0 mg every 8 hours PRN for agitation, initiated on 09/04/13 and discontinued on 09/17/13 * Scheduled Haldol 2.0 mg twice a day (BID), initiated on 09/17/13 and changed to 1.0 mg at 8:00 a.m. and 2.0 mg at 8:00 p.m. on 10/09/13 * Seroquel (an antipsychotic medication) 25 mg at bedtime (HS), initiated on 09/04/13 and discontinued on 09/09/13 * Zyprexa (an antipsychotic medication) 2.5 mg at HS, initiated on 09/10/13 Resident #7's current care plan stated: * "Focus: Anxiety, resistive to carse, resistive to redirection when leaves the bdlg [building], I cont [continue] to have increased confusion, behaviors, and metal problems. I have had delusions, I can be verbally and physically abusive to staff, and my actions are not always appropriate . . . wanders into other res [resident] rooms . . . Shows profound cognitive impairment. . . . Interventions: I have a wanderguard; If res. anxious, she loves cats. Assist her with seeing the cat; Meds [medications] per drs. [doctor's] 10-9-13 haldol med changed; Neuropsych eval [evaluation] done 10-9-13 . . ."	F 309		

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F 309	Continued From page 4 * "Focus: I use psychotropic medications (Ativan) r/t [related to] anxiety . . . Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness; Monitor/record occurrence of behavior symptoms (Specify: pacing, wandering, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol . . ." The care plan failed to identify specific/individualized interventions related to Resident #7's behaviors. Review of Resident #7's August and September 2013 medication administration records (MARs) identified the following: * PRN Ativan administered 15 times from August 25 to September 04. Facility staff failed to provide and/or document non-pharmocological intervention attempted prior to the administration of Ativan eight of the 15 times. * PRN Haldol administered 17 times from September 04 to 16. Facility staff failed to provide and/or document non-pharmocological interventions attempted prior to the administration of Haldol 12 of the 17 times. The facility failed to assess and determine causative factors which may have contributed to Resident #7's behaviors, implement interventions for the specific behavior, and evaluate the interventions for effectiveness. This resulted in facility staff utilizing medications for Resident #7's behavioral symptoms rather than attempting non-pharmocological interventions. - Review of Resident 1's medical record occurred on all days of the survey. Diagnoses included anxiety and dementia. Medications included	F 309		

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F 309	Continued From page 5 alprazolam 0.25 mg every evening before bedtime, initiated on 10/04/13, and alprazolam 0.25 mg PRN three times per day for anxiety, initiated on 08/05/13. Resident #1's current care plan stated: * "Focus: I am at risk for trying to leave the facility . . . I also wander into other res [resident] rooms . . . Interventions: . . . Staff will approach me and redirect me when I am wandering into other res rooms. Wife state that when res was agitated try holding his hand and saying the Lords Prayer or trying icecream [sic] as this helped in the past sometimes." * "Focus: . . . I have mood behavioral issues . . . Interventions: Monitor/record occurrence of for [sic] behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol . . ." Review of the nursing progress notes, dated 09/01/13 through 11/13/13, revealed the facility staff failed to implement and document non-pharmocological interventions attempted before administering PRN alprazolam 39 of the 47 times administered. During an interview, on 11/13/13 at 4:30 p.m., an administrative staff nurse (#1) stated nurses should have charted interventions tried in the progress notes before administering PRN medications.	F 309		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive	F 325	F-325: Maryhill Manor is committed to providing nutritional support to assist residents in maintaining a healthy nutritional status and weight. Continued on next page	12-19-13

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F 325	Continued From page 6 assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of a professional reference, and staff interview, facility staff failed to implement appropriate interventions to restore/maintain adequate nutritional status for 1 of 1 sampled resident (Resident #7) identified with severe weight loss. Failure to implement interventions and/or evaluate the effectiveness of current interventions resulted in Resident #7 experiencing severe weight loss. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the parameters for evaluating significance of unplanned & undesired weight loss: Interval — Significant Loss — Severe Loss 1 month — 5% (percent) — Greater than 5% 3 months — 7.5% — Greater than 7.5% 6 months — 10% — Greater than 10% Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, unspecified psychosis, anxiety, and congestive heart failure (CHF). Daily	F 325	Continued from previous page 1. Resident #7 selects what she wants to eat and pushes food away when she does not want to eat. She is given food at all times of the day and night whenever she wishes to eat. To enhance the care provided, resident #7, along with her caregivers and family, will be interviewed by the Dietitian and Dietary Manager to determine if there are other food preferences or approaches that may enhance her nutritional status. Resident #7's plan of care has been reviewed and the following have been added at this time: a. Fortified hot cereal with breakfast b. Snacks in room that she can snack on at any time. c. Alternating Ensure and juice supplement. 2. All residents at risk of weight loss will be monitored weekly by the Dietician and Dietary Manager. The residents weight and plan of care will be reviewed. The current nutritional plan will be assessed for effectiveness by checking intakes and interviewing residents and caregivers. Continued on next page	

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F 325	Continued From page 7 medications included Haldol, Zyprexa (both antipsychotic medications), Lasix, and spironolactone (both diuretic medications). The admission Minimum Data Set (MDS), dated 08/28/13, identified Resident #7 had both long and short term memory problems and independent with eating. Resident #7's care plan stated, "Nutrition Hydration, CHF, HTN [hypertension], Significant weight loss . . . Interventions: 8 oz [ounce] choc [chocolate] Ensure Plus [a nutritional supplement initiated on 10/30/13] pm and hs [bedtime]. Offer snacks prn [as needed]; Hot choc with meals [initiated on 10/09/13]; Regular diet . . ." Resident #7's initial nutritional assessment, dated 08/27/13, identified a weight and height of 127.6 pounds and 54 inches; no weight loss during the last three months; suffered psychological stress or acute disease in the past three months; no psychological problems such as dementia or depression; and at risk for malnutrition. Review of Resident #7's weights (tub scale) revealed the following: * 08/22/13 - 127 pounds * 09/22/13 - 118 pounds * 10/24/13 - 101.1 pounds * 11/07/13 - 100 pounds These weights identified a 27 pound weight loss (21%) in 11 weeks. Review of Resident #7's dietary progress notes identified the following: * 08/27/13 - "Heart Healthy diet. Eating [greater than] 75% of meals. Eating per self. Weight 127# [pounds]. . . . CHF, weight up and down approx [approximately] 7-10# secondary to edema and	F 325	Continued from previous page 3. a. A policy regarding protocols for weight loss prevention and interventions will be developed which outlines specific tasks and delineates the responsibilities of various departments and disciplines. b. A meeting with be held on 12/10/13 with the Nursing Services Coordinator, Dietician, and Dietary Manager to review how to put individualized tasks into the C.N.A. charting program and how to check the history of this documentation. c. A meeting will be held with the dietary department and C.N.A. staff to review proper charting on 12/16/13. 4. A Quality Assurance check will be completed by the Dietician or Dietary Manager monthly for the next three months, and quarterly for a minimum of one year. The QA check will monitor the following: a. Are individualized interventions in place on the care plan? b. Are the individualized approaches appropriately entered into the nourishment sheet and electronic display in the kitchen? c. Are individualized approaches in place in Point of Care for documentation? d. Are the individualized approaches being offered consistently? e. Is the intake of the individualized approaches documented in the electronic record? f. Has the acceptance of the approaches been evaluated and revisions implemented as needed?	

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F 325	Continued From page 8 diuresis." * 09/03/13 - "Heart healthy diet due to Dx [diagnoses] of CHF . . . Eating [greater than] 50% 2 out of 3 meals daily. Is refusing some meals. Eats per self. Weight 129# is on lasix wt may fluctuate . . ." * 09/04/13 - " . . . Visited with resident and wife regarding low sodium foods . . . Weight 120# and down 9# due to diuresis" * 09/18/13 - "Diet change to Regular." * 10/02/13 - ". . . down 9# past week and down 21# past 3 weeks." * 10/9/13 - "Likes chocolate. Offer chocolate milk prn and hs. Hot choc with meals . . . Weight 109# and stable past week. Down 8# past 3 weeks." * 10/16/13 - ". . . Weight 108# and stable past 3 weeks." * 10/21/13 - ". . . Offering chocolate milk prn and hs. Hot choc with meals . . ." * 10/31/13 - ". . . Weight 101#. Down 8# pawt [sic] 3 weeks. Not always able to make needs known. Nursing requesting Ensure Plus chocolate pm and hs." * 11/6/13 - ". . . Hot choc with meals. Weight 102#. Not always able to make needs known. Ensure Plus chocolate pm and hs." Resident #7 lost an anticipated seven to nine pounds (depending on the scaled used) related to edema and diuresis as identified in the dietary progress note dated 09/04/13. The dietary notes identified an additional 19 pound weight loss from 09/04/13 to 10/31/13. On 10/30/13, per nursing request, the dietician added Ensure Plus to Resident #7's diet. The dietician conducted no further assessment of the resident's needs and failed to monitor her consumption of the Ensure. Observations on 11/13/13 at 9:55 a.m., 12:05	F 325		

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F 325	Continued From page 9 p.m., and 5:00 p.m. showed Resident #7 in the dining room for meals. The facility staff failed to serve her hot chocolate or chocolate milk. During an interview on 11/14/13 at 10:05 a.m., the dietary manager (#2) stated the dietary card did not identify Resident #7 received hot chocolate with every meal but the dietary staff are expected to serve it with every meal. He stated the resident receives Ensure twice a day but the staff do not document her consumption. Failure of the facility to assess Resident #7's weight loss, implement dietary interventions in a timely manner, and monitor intake resulted in the resident experiencing a severe weight loss or 27 pounds in an 11 week time period.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	F-329 Maryhill Manor is committed to providing care that keeps a resident free from unnecessary drugs. To that end, Maryhill will do the following to enhance our system of monitoring medication use: 1. This issue was discussed with the physician for resident #6 on 12/4/13. He has written additional documentation on his reasons for maintaining the dose at its current level. 2. All residents receiving psychotropic medication may be affected by the need for continual assessment for appropriateness and efforts to reduce dosages. Continued on next page	12-19-13

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F 329	Continued From page 10 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 1 of 6 sampled residents (Resident #6) receiving an antipsychotic medication. Failure to attempt a GDR (gradual dose reduction) (unless contraindicated) in an effort to discontinue antipsychotic use may result in residents receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: Review of the facility policy titled "Psychotropic Medication Policy" occurred on 11/14/13. This policy, dated September 2013, stated, ". . . Maryhill Manor will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the long term care facility to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. . . . Efforts to reduce dosage or discontinue of [sic] psychopharmacological medications will be ongoing, as appropriate, for the clinical situation. . . . Reviews of the use of the medication with the physician, the DON [director of nursing], the pharmacy consultant, and nursing service will be	F 329	Continued from previous page 3. A letter was sent to physicians and physician assistants explaining the need for good documentation when responding to the pharmacists' requests for efforts to reduce dosages. 4. A Quality Assurance check will be completed by a nurse under the direction of the Nursing Services Coordinator monthly for the next three months, and quarterly for a minimum of one year. The QA check will monitor the following: a. Was the physician asked to consider dose reduction or discontinuation of a psychotropic medication? b. Did the physician document specific contraindications for a reduction in dose if one was not attempted?	

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F 329	Continued From page 11 ongoing to determine the continued presence of target behaviors and or the presence of any adverse effects of the medication use. . . The physician will need to document in the chart the reason for not tapering the dose at that time. . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia with behaviors, anxiety, and depression. Current medications included Seroquel (an antipsychotic) 12.5 mg (milligrams) twice a day (dose present on admit, 01/28/13). Resident #6's current care plan stated, ". . . Focus . . . I have impaired cognitive function et [and] impaired thought processes r/t [related to] dementia. Repetitive phrases. . . ." The resident's care plan failed to identify target behaviors or address Resident #6's use of Seroquel. Minimum Data Set (MDS) assessments, dated 10/28/13, 07/28/13, 04/28/13, and 02/03/13, did not identify any behaviors (such as verbal/physical, rejection of care, wandering, etc.). A "Consultant Pharmacist's Medication Review," dated 10/10/13, stated, ". . . Seroquel . . . Recommend gradual dose annually . . . Please consider GDR or document why not appropriate . . ." The physician responded to the pharmacist: "Needs it," and did not attempt a GDR. Physician's progress notes since Resident #6's admission on 01/28/13 failed to identify a GDR attempt of Seroquel, and failed to identify specific contraindications for a GDR of Seroquel. During an interview on 11/14/13 at 9:45 a.m., a	F 329		

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	355108	A. BUILDING _____ B. WING _____	11/14/2013

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F 329	Continued From page 12 supervisory nurse (#1) stated Resident #6 makes repetitive verbalizations so the physician did not feel he should adjust her medications.	F 329		
F 431 SS=F	483.60(b), (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.	F 431	**F-431** Maryhill Manor is committed providing the safe handling and distribution of all drugs and biologicals. Also, the pharmacies we work with track and report all dispensed scheduled II drugs daily to the state, thus ensuring that medications are not reordered before they should be. To further enhance our security of medications, Maryhill will do the following: 1. The pharmacies have been contacted about the amount of medications that are delivered and will reduce the amounts to better fit what our medication carts can hold, thus reducing the amount of medications stored in the safe. 2. A sign-in and sign-out sheet will be developed and placed with the safe. Two nurses (RN/LPN) or a nurse (RN/LPN) and Medication Aide II (MAII) will sign out any medications that are removed from the safe and placed into the medication carts. The pharmacist and Nursing Services Coordinator will count and reconcile the inventory with the sign-in and sign-out sheets on a monthly basis. Continued on next page	12/19/13

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F 431	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, review of pharmacy policy and procedure, and staff interview, the facility failed to ensure periodic reconciliation (accurate account) of controlled medications in 1 of 1 storage safe. Failure to periodically reconcile controlled medications has the potential for medication loss or diversion of medications. Findings include: Review of the consultant pharmacy policy titled "Controlled Medication Storage," dated September 2013, stated, ". . . A controlled medication accountability record is prepared by the facility for all Schedule II medications regardless if routine or PRN [as needed] . . . At each shift change, a physical inventory of all controlled medications, including the emergency supply, is conducted by two licensed nurses . . . If a PRN controlled medication is supplied in the automatic exchange system it will need to be physically inventoried at each shift change. . . ." Observation of the locked medication storage area in the main nurse's station occurred on 11/14/13 at 9:25 a.m. with a licensed nurse (#3). Observation showed a locked safe which contained controlled medications in the storage area. The nurse stated only the charge nurse has the keys to the storage area and the combination to the safe. She stated the safe does not have a log book and medications in the safe are not counted between shifts. The medications in the safe are only counted when they are removed from the safe and placed in the locked drawer on	F 431	Continued 3. All narcotics waiting to be destroyed will be removed from the nurses station and placed in a double locked area in the Nursing Services Coordinator's office until destroyed. Nurses will be educated on these new procedures 12/17/13. 4. Quality Assurance will be completed by the Nursing Services Coordinator or their designee once a month for three months and quarterly for one year as follows: a. Were all medications from the safe accounted for on the sign-in and sign-out sheets? b. Does the physical inventory match the sign-in and sign-out sheets?	

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F 431	Continued From page 14 the medication cart. The safe contained the following Schedule II medications: * Fentanyl Patches 12 micrograms (mcg) - 1 box of 5 patches * Fentanyl Patches 25 mcg - 1 box of 5 patches * Oxycodone 5 mg - 4 cards with 30 tablets on each card * methadone 10 mg - 6 cards with 30 tablets on each card Other medications contained in the safe included: * Phenobarbital (Schedule IV) 20 milligrams (mg) per 5 milliliters (ml) - 1 bottle containing 437 ml * alprazolam 0.25 mg (Schedule IV) - 3 cards with 30 tablets on each card and 1 card of 14 tablets * alprazolam 0.5 mg - 2 cards with 30 tablets on each card * alprazolam 1.0 mg - 2 cards with 30 tablets on each card * lorazepam 0.5 mg (Schedule IV) - 155 tablets * clonazepam - 1.0 mg (Schedule IV) - 1 card of 30 tablets * Tramadol 50 mg (Schedule IV) - 333 tablets * Tylenol with Codeine (Schedule III) - 1 card of 30 tablets * hydrocodone (Schedule III) 5/325 mg - 4 cards with 62 tablets on each card; 1 card of 16 tablets; 2 cards with 31 tablets on each card; 3 cards with 30 tablets on each card * hydrocodone 5/500 mg - 1 card of 62 tablets * hydrocodone 7.5/325 mg - 1 card of 30 tablets * hydrocodone 10/325 mg - 1 card of 30 tablets Observation of the narcotic log book showed staff failed to include the narcotics in the safe in the count. During an interview on 11/14/13 at 10:35 a.m., an	F 431		

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F 431	Continued From page 15 administrative nurse (#1) agreed they do not have a good system of accountability for controlled medication. During an interview on 11/14/13 at 11:59 p.m., the West wing medication aide (MA) (#4) stated she has keys for the medication storage cupboard located in the main nurse's station and knows the combination to the safe. She stated all the MAs and nurses know the combination to the safe.	F 431		