STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355041	A. BUILDING _____ B. WING _____	C 01/30/2014

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LUTHERAN HOME OF THE GOOD SHEPHERD	1226 1ST AVE N NEW ROCKFORD, ND 58356

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification and complaint survey started on January 27, 2014 and completed on January 30, 2014, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, professional reference review, and staff interview, the facility failed to follow professional standards of quality for 1 of 1 sampled resident (Resident #1) observed receiving crushed and concealed medications. Failure to administer medications in a way that ensures the nurse knows which medications the resident actually consumed may result in the resident only getting some or none of certain medications which may be harmful to the resident. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 848, stated, ". . . Routes of Administration . . . When administering a drug, the nurse should ensure that the pharmaceutical preparation is appropriate for the route specified . . . Administering Oral Medications . . . If it is	F 281	1. This issue has been resolved in relation to F281 for Res. #1 Doctor has changed order for the med that should not be crushed to a comparable med that may be crushed. (See attach. 1) Education was given at the nurses meeting to staff in relation to using smallest amount of an appropriate substance to conceal meds as possible. We will avoid using a favorite food to conceal med or to ease the swallowing. This will allow nurse to know the actual amount of medication consumed. We also discussed with nurses timing of medications, i.e. before meals. See nursing meeting notes and roster of attendance. (See attach. 2a-2c). 2. The facility has updated the policies and procedures to prevent further issues in this area. (See attach. 3a-3b). 3. The facility will review medications of all residents who require medications to be crushed, emptied, or altered in any form. Pharmacy will review medication administration records to assure we are continuing to administer appropriately.	02/05/14 03/03/14

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

Administrator 3-5-14

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 281	Continued From page 1 acceptable, crush the tablets to a fine powder with a pill crusher or between two medication cups. Then, mix the powder with a small amount of soft food (e.g., custard, applesauce) . . Clinical Alert, Check with the pharmacy before crushing tablets. Sustained-action, enteric-coated, buccal, or sublingual tablets should not be crushed . . . All Medications . . Stay with the client until all medications have been swallowed Rationale: The nurse must see the client swallow the medication before the drug administration can be recorded . . Document each medication given . . If medication was refused or omitted, record this fact on the appropriate record; document the reason, when possible, and the nurse's actions according to agency policy. . . ." The "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Pennsylvania, page 934-935, stated, ". Prilosec . Indications . . . Symptomatic gastroesophageal reflux disease . . . Administration, P.O. [oral], Don't open or crush tablets or capsules . ." Page 1444 stated, " . Aggrenox . . . to decrease risk of stroke . . . Swallow capsule whole. . . ." Review of Resident #1's medical record occurred on January 27-30, 2014 and diagnoses included Parkinson's disease, dementia, gastroesophageal reflux disease, hypertension, history of a cerebrovascular accident (stroke), hyperlipidemia, and breast cancer. Current oral medications included Prilosec (used for gastroesophageal reflux disease), Sinemet (used for Parkinson's disease), metoprolol tartrate (used for high blood pressure), lisinopril (used for high blood pressure), Norvasc (used for high blood pressure), Aggrenox (used to thin the blood),	F 281	Medication dosage forms will be reviewed with the doctor if resident has a change in needs or condition. Education will be done on a continuing basis. The facility has updated the list of medications that should not be crushed using "Oral Dosage Forms That Should Not Be Crushed" from the Institute for Safe Medication Practice by John F. Mitchell, Pharm D., and was last updated on January 2014. Initial education was given at nurse's meeting. (See attach. 2a-2c) 4. The facility plans to monitor these stated procedures weekly X 4, monthly X 3, then quarterly X 3. Monitoring will be completed by DON or designee starting week of 3/3/14. See QA (See attach. 4a-4b). 5. The Lutheran Home of the Good Shepherd will be in substantial compliance with F 281 by 3/3/14.	02/03/14 02/05/14 03/03/14 03/03/14

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F 281	Continued From page 2 Aricept (used for dementia), Zocor (used to decrease cholesterol), and letrozole (used to treat breast cancer). Review of a physician order, dated 01/23/14, stated, "Conceal meds in food/drinks - when res [resident] refuses meds " On the morning of 01/28/14, a nurse (#8) stated she usually crushed Resident #1's pills and put them in a milkshake to get her to take her medications. The nurse (#8) identified Resident #1 took her pills whole with water on the morning of 01/28/14 and she (#8) did not need to conceal them in ice cream. On the morning of 01/29/14, the nurse (#8) stated Resident #1 took her Prilosec capsule whole and the nurse (#8) opened the Aggrenox capsule, crushed her other pills, and mixed all the medications into the resident's 180 milliliter "Suppetrol" weight loss supplement. The nurse (#8) later verified Resident #1 consumed half of the mixture and documented on the Medication Administration Record as "took 1/2 [one-half] malt that meds in" for the resident's 8:00 a.m. meds on 01/29/14. During an interview on 01/30/14 at 8.30 a.m., another staff nurse (#5) stated when Resident #1 doesn't take her medications whole, she opened up the Prilosec and Aggrenox capsules, crushed the other medications, and mixed them all with ice cream. Crushing and mixing all of Resident #1's medications in a large amount of liquid does not allow the nurse accurate monitoring of the medication and knowledge of the actual amount taken. The facility staff members' practice of opening Resident #1's Prilosec and Aggrenox capsules does not follow professional standards of practice (both should be swallowed whole).	F 281		

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to implement interventions to aid in the healing and prevention of pressure ulcers for 2 of 5 sampled residents (Resident #1 and #7) with a pressure ulcer. Failure to provide pressure-relieving interventions may result in the worsening of a current pressure ulcer (Resident #1) or the development of a facility-acquired pressure ulcer (Resident #7). Findings include: Review of the facility policy titled "Pressure Ulcers/Stasis Ulcers/Other Skin Concerns" occurred on 01/30/14. This policy, revised August 2008, stated, ". . . Procedure: 1. When a concern regarding skin issues is determined by nursing service or other source, the issue will be referred to the skin monitoring team. 2 Appropriate interventions will be determined by the interdisciplinary skin concern team These measures may include dietary interventions, mattress and/or w/c [wheelchair] cushions, or	F 314	1. Res. #1-physician order clarified to wear protective boots at all times bilaterally except during direct foot cares. (See attach. 5) Res. #7 This was corrected by getting an additional cloud cushion and placing it into the recliner. Both seating areas now have their own cloud cushion and are no longer being interchanged. (See attach. 6). Education was offered about the importance of knowing the residents care plan and following it so any risk factor is recognized and early preventive interventions are put in place. Updated "Skin Integrity Policy and Procedure" and shared in both Nursing and CNA meetings. (See attach. 13a-13-d and 2a-2c) 2. Systematic changes to help identify other residents who could be affected include: The Braden Scale will now be used and additional assessments from the electronic Wound Assessment Manager (WAM) will be used to identify those at risk for developing skin issues (See attach. 7-7i) A Nutritional Assessment will be completed with all new residents within 72 hours of admission, quarterly, with hospital returns, as well as annually and with any significant change in status. The assessment will be used to evaluate the	02/03/14 01/30/14 03/05/14

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F 314	Continued From page 4 special seating system. Additional measures will be determined on an individual basis. 3. Additional medical concerns will be considered when interventions are being planned. 4. Staff will be educated on pressure ulcer prevention at least yearly and as needed." - Review of Resident #1's medical record occurred on all days of survey and diagnoses included Parkinson's disease, diabetes, history of a cerebrovascular accident, and a current Stage 2 pressure ulcer to the left heel (measurement on 01/29/14 identified a 3 centimeter (cm) by 1 cm Stage 2 pressure ulcer). The significant change Minimum Data Set (MDS), dated 11/28/13, identified the resident required extensive assistance for transfers and had a Stage 2 pressure ulcer. A physician's order, dated 11/27/13, stated, "Blue pressure relieving boot to [left] foot [at] all times - blue boot to [right] foot while in bed." The current care plan stated, ". . .[Resident #1] requires staff assistance for all ADLs [Activities of Daily Living] . . . EZ stand [mechanical stand lift] transfers . . . Stage 2 pressure ulcer to left heel . . . Pressure relieving boot to left foot at all times . . . blue boot to right foot while in bed . . . I have pain at times in my left heel. . ." Observation on 01/28/14 at 2:00 p.m., showed Resident #1 in bed with bilateral heel boots. A Certified Nursing Assistant (CNA) (#6) removed Resident #1's heel boots, applied gripper socks, and transferred her from bed to the toilet, and then to her wheelchair with a mechanical stand lift. The CNA (#6) stated she was unsure if the resident wore the heel boots when out of bed.	F 314	resident for any nutritional concerns that may contribute to skin breakdown. (See attach. 8a-8c) A skin monitoring review will be completed with each resident's whirlpool bath to recognize any abnormal looking skin concerns that may not have previously been documented. (See attach. 9) The facility's new computer program has also allowed the facility to place a button that will fire at every shift asking the CNA whether there has been a skin concern recognized. Nurse is then notified. 3. Systemic changes put into place include revised policy and procedures. (See attach. 10a-10d). Nurses meeting. (See attach. 2a-2c) Educational courses on pressure sores, repositioning and skin issues provided through Health Care Academy for nurses and CNAs. (See attach. 11a-11b). CNA Knowledge Survey on pressure sores provided to CNAs. (See attach. 12) Correct answers will be reviewed at CNA meeting. CNA meeting (See attach. 13a-13d)	03/05/14 02/10/14 02/10/14 02/05/14 02/26/14 03/05/14

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F 314	Continued From page 5 During an interview on 01/29/14 at 8:15 a.m., a nurse (#8) stated Resident #1 should have the heel boot on her left foot at all times, including during transfers. - Review of Resident #7's medical record occurred on all days of survey and diagnoses included Parkinson's, dementia, left hip fracture (September 2013), history of a pressure sore to the buttocks/coccyx (healed 12/24/13), and a current pressure ulcer to the left heel. The re-admission MDS, dated 12/20/13, identified moderately impaired cognition, extensive assistance for transfers, and a Stage 2 pressure ulcer. A physician's order, dated 12/13/13, stated, "Cloud cushion to be used between w/c [wheelchair] and recliner." The current care plan stated, "Problem: I have a has [sic] potential for skin breakdown . . . 12/27/13 lt [left] heel breakdown . . Approaches: . . . w/c cushion - see bedside care kardex . " The beside care kardex, located in the CNA book at the nurse's station, identified a "cloud cushion" to be used between the wheelchair and the resident's recliner. Random observations on all days of survey showed Resident #7 seated in a recliner in his room. Facility staff failed to move the pressure-reducing cushion from the wheelchair to the recliner when the resident transferred between the two.	F 314	Laminated sheets were provided at each nurses station showing the most common pressure points and warning signs of pressure ulcers. (See attach. 14) Laminated note cards with pictures of all staged and unstageable ulcers along with how to correctly document pressure ulcers were placed in each nurses cart. (See attach. 15). A skin team has been developed and an interdisciplinary team meets weekly. Skin issues and residents who have been recognized as being at risk for pressure ulcers will be addressed at the skin meetings. 02/04/14 4. Quality Assurance plan has been developed and will monitor weekly X 4, monthly X3, and quarterly X 3. Monitoring will be completed by DON or designee starting week of 3/3/14. (See QA attach. 16a-16b). 03/05/14 5. The Lutheran Home of the Good Shepherd will be in substantial compliance with F314 by 3/5/14. 03/05/14	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a	F 325	1.Res. #1-Staff spoke with husband on 1/30/14 and discussed additional	

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F 325	Continued From page 6 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, facility policy review, and staff and family interview, facility staff failed to implement appropriate interventions to restore/maintain adequate nutritional status for 1 of 3 sampled residents (Resident #1) with weight loss. Failure to implement interventions and/or evaluate the effectiveness of current interventions resulted in Resident #1 experiencing severe weight loss. Findings include: Review of the facility policy titled "Weight Loss Concern Policy" occurred on 01/30/14. This policy, revised August 2008, stated, "Purpose: To promote adequate nutrition to maintain or attain optimal weight status when appropriate Procedure: 1. When a concern regarding weight loss is determined by either nursing or dietary, it will be brought before the weight loss team. 2. Appropriate interventions for the weight loss will be determined by the interdisciplinary weight loss team with doctor input as needed. 3. Appropriate interventions will be instituted. 4. Additional medical concerns will be considered when interventions being planned."	F 325	likes and dislikes regarding food and fluids. Current nutritional assessment was done on res #1.(See attach. 17a-17e). Resident is also offered food on a smaller plate during food service so portions look less overwhelming. Dietary aid is asking Res. #1 at meals what she would like to eat and offering choices. Additional snacking items are available in her room. Res #1 is reviewed in our weekly weight interdisciplinary meetings. 03/05/14 2. All residents will be reviewed at a weekly weight meeting to recognize early weight loss or gain and review interventions for effectiveness. 03/05/14 3. Systemic changes include the following: Dietary manger will run weight report and percentage eaten every Monday. Dietary manager will compare and share identified changes in weights for team review. Nutritional assessment will be done within 72 hours of admission, readmission, significant change, quarterly and annually. (See attach. 8a-8c)	

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F 325	Continued From page 7 Review of Resident #1's medical record occurred on January 27-30, 2014 and diagnoses included history of a cerebrovascular accident, Parkinson's disease, dementia, diabetes, breast cancer, and a current Stage 2 pressure ulcer to the left heel. The significant change Minimum Data Set, dated 11/28/13, identified the resident with severely impaired cognition, required extensive assistance for eating, weighed 185 pounds (lbs), no weight loss or gain, on a mechanically-altered and therapeutic diet, and a Stage 2 pressure sore Resident #1's current diet card identified a liberal diabetic diet, mechanically soft with ground meats. The diet card showed the resident liked eggs, toast with jelly, caramel rolls, coffee, banana cream pie, ham, turkey, lunch meat, and orange juice. The resident's dislikes included milk, pork, ground beef, corn, beets, and grilled cheese sandwiches. During an interview on 1/28/14 at 3:30 p m , Resident #1's husband stated she enjoyed eating soup, ice cream, and milkshakes. (The facility failed to identify these "likes" on the resident's diet card.) The current care plan stated, ". . Problem: Potential for weight loss related to leaving 25% or more of food uneaten at most meals . . Goal. Resident will not lose more than 5% [sic] her current weight in 1 month . . . Approaches. Supplements per order, Dietician to evaluate current resident nutritional status, Maintain accurate and current listing of resident food likes and dislikes, Ensure that meal trays are served with foods at appropriate temperatures, appropriate seasonings, and attractive,	F 325	We have updated the "Weight Loss Concern Policy. (See attach. 18). Staff have been educated on dietary preference book i.e. Dietary cards in each kitchenette. (See attach. 13a-13d) Educated dietary and nursing on rapid response to the resident specific requests for food. Requested foods are not to be used to conceal medications. (See attach. 2a-2c, 13a-13d and 19). 03/05/14 4. Monitor weekly x 4, monthly X 3 and quarterly X 3. Monitoring will be completed by DON or designee starting week of 3/3/14. (See attach. 20a-20b) 03/05/14 5. Lutheran Home will be in substantial compliance with F 325 as of 3/5/14. 03/05/14	

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F 325	Continued From page 8 Supplement meal intake with between-meal nourishing snacks, Document food intake at each meal and evaluate trend weekly, Promptly offer resident food alternatives when appropriate for any meal served, Provide verbal encouragement with ingesting meals, Monitor weights and promptly report significant weight loss or developing trend of continued weight loss, If appropriate, consider asking family/friends to bring resident 'favorite' foods (husband brings shakes from home that resident enjoys) . . Problem: Stage 2 pressure ulcer to left heel . . . Approaches: . . . Provide diet high in protein, with inbetween meal snacks, Record food intake % at each meal. Report any decline to physician and dietician, Offer food substitutes if resident refuses to eat . . . ." Review of Resident #1's weight record identified the following. *11/01/13 - 196 pounds (lbs) (weight on admission) *11/29/13 - 187 lbs - 9 lb weight loss in one month (4.6%) *12/04/13 - 184 lbs - 12 lb weight loss in 33 days (6.1%) *01/03/14 - 181 lbs - 15 lb weight loss in nine weeks (7.7%) *01/22/14 - 176 lbs - 20 lb weight loss in 11 weeks and 5 days (10.2%) *01/29/14 - 174 lbs - 22 lb weight loss in 12 weeks and 5 days (since admission) (11.2%) Review of Resident #1's dietary progress notes identified the following: *11/05/13 - "New admit . . . Liberal diabetic diet [with] ground meat averaging 55%/55%/42% [meal intakes] since admit. Estimated needs: 1780 calories, 71-89 gms [grams] protein, [and]	F 325		

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F 325	Continued From page 9 2225 cc [cubic centimeters] fluids. Ht [height] 66" [inches]. Wt [weight] 196 # [lbs]. BMI [body mass index] 31.6 - obese." *12/10/13 - "Gradual wt loss [and] pressure sore. Wt 184# . [Down] 6#/ [in one] month (3.2%) [and] [down] 12#/ [since] admit (6.1%). BMI is 29 7. Liberal diabetic diet [with] ground meat averaging 64%/31%/70% [meal intakes] past 7 days. Arginaid BID [powder packet] was started Will discuss at Nutrition Risk." *01/10/14 - "Gradual wt loss. Wt 179#, [down] 4#/month, [and] 17#/admit (8.7%). BMI 28.9 . Meals averaged 24%/30%/68% past 7 days. Recommend d/c Arginaid as pressure sore healed. Will be discussed at Nutrition Risk . Husband brings in milkshakes." (Resource Arginaid was not discontinued.) *01/28/14 - "Sign [significant] wt loss [and] pressure sore on heel. Wt 176#, [down] 6 #/month (3.3%), [and] [down] 20#/admit (10 2%). BMI is 28.4 Liberal diabetic diet [with] gr [ground] meat averaging 10%/17%/80% past 7 days. Receives Arginaid [resource powder packet] and beneprotein. Will discuss at Nutrition Risk to see if cal [calorie] enhanced [and]/or supplement need to be started. Estimated needs 2000-2400 calories, 80 gms protein . . . [and] 2400 cc fluids." Review of Resident #1's progress notes identified on 11/23/13 staff moved the resident to a staff assisted table for meals. Nutrition Risk meeting notes identified the facility obtained a physician order on 11/23/13 to start Resource Arginaid one packet twice a day until the resident's wound healed. The facility failed to implement any additional nutritional supplements from 11-29-13, when Resident #1 experienced a nine pound weight loss, until 01/29/14.	F 325		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355041	A. BUILDING _____ B. WING _____	C 01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 325	Continued From page 10 Observation on 01/28/14 at 8:00 a.m. showed Resident #1 eating breakfast in the dining area and a Certified Nursing Assistant (CNA) (#9) encouraging the resident to eat. The resident ate one-half piece of toast, a few bites of oatmeal, and drank all of her Resource Arginaid (protein supplement). The CNA (#9) asked the resident if she wanted some ice cream and the resident said, "Yes. Chocolate." The CNA (#9) asked a dietary staff member (#10) for some ice cream. After the dietary staff member (#10) prepared the ice cream (mixed chocolate syrup with vanilla ice cream) she placed it in the freezer and told the nurse (#8) it was available for med pass. Staff failed to give Resident #1 the ice cream she requested during breakfast. During an interview on the morning of 01/28/14 with the nurse (#8), she stated Resident #1 took her pills whole with water that morning and she (#8) did not need to use the ice cream. Observation on 01/28/14 at 4:30 p.m. showed the ice cream prepared for Resident #1 during breakfast remained in the freezer. Observation on the morning of 01/29/14 identified the nurse (#8) crushed Resident #1's morning medications and mixed them with her "Suppetrol" weight loss supplement prepared in advance for the noon meal. The resident consumed half of the mixture. (Crushing Resident #1's medications and placing them in her ice cream/milk shakes may result in the resident developing an aversion to a food she enjoys and consumes on a regular basis) During an interview on the morning of 01/29/14, a dietary staff member (#3) stated staff assist and encourage Resident #1 during meals but she does not eat much without her husband present.	F 325		

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F 325	Continued From page 11 The staff member (#3) stated the resident loves ice cream and her husband brings her a milkshake every day. The dietary staff member (#3) confirmed the resident's record lacked additional documentation regarding her weight loss, and stated on 01/29/14, the facility implemented a calorie enhanced diet and "Suppetrol" twice daily (dinner and supper). The staff member (#3) stated staff made "Suppetrol" at the facility and it consisted of Nutriplus ice cream mixed with an instant breakfast mix. During an interview on the afternoon of 1/29/14, an administrative nurse (#1) stated the physician ordered Resource Arginaid (low calorie, high protein) on 11/23/13 for the resident's pressure ulcer. The staff member (#1) stated the facility contacted the physician on 01/28/14 to change the Resource Arginaid to Arginaid Plus (increased calories). On the afternoon of 01/28/14, a dietary staff member (#11) verified the Resource Arginaid packet contained 25 calories and a higher amount of protein for wound healing and the Arginaid Plus contained 250 calories and a significant amount of protein. Resident #1 experienced a 12 lb (6.1%) weight loss in just over a month and a severe 20 lb (10.2%) weight loss in approximately three months. The facility failed to implement dietary interventions in a timely manner and evaluate the effectiveness of existing interventions which resulted in Resident #1's continued weight loss	F 325		
F 425 SS=B	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	1. Expired medications were immediately removed from the medication cart.	

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F 425	Continued From page 12 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the removal of expired medications located in 2 of 4 medication carts (Grace Court and Peace Lane/Hope Avenue/Joy Street). Failure of facility staff to ensure the removal of expired medications from the medication carts may result in resident's receiving these expired medications and possible adverse affects. Findings include: On the morning of 01/30/14 observation of the medication cart located on Grace Court with a staff nurse (#4) identified an expired date on	F 425	2. Monitoring of OTC medications began on 2/7/14. 3. Policy for "OTC medication review" was developed to continually monitor (See attach. 21). 4. Will monitor weekly X4, monthly X3, and quarterly X 3. (See attach.22) 5. Lutheran Home of the Good Shepherd was in compliance of F 425 as of 1/30/14.	/30/14

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F 425	Continued From page 13 one-over-the-counter (OTC) medication. * Imodium 2 mg (milligrams), expired in March 2013 On the morning of 01/30/14 observation of the medication cart for Peace Lane/Hope Avenue/Joy Street with a staff nurse (#5) identified expired dates on two OTC medications. * Acetaminophen 500 mg, expired in September 2013 * Multivitamin/Iron Supplement, expired in October 2013 On 01/30/14 at 2:20 p.m., an administrative staff member (#2) stated it is the nurse's responsibility to go through the OTC medications in the medication cart. This staff member stated the facility did not have a policy to ensure outdated medications were removed and replaced	F 425		
F9999	FINAL OBSERVATIONS Based on observation, record review, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		