STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355089	A. BUILDING _____ B. WING _____	06/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PARK RIVER	301 COUNTY RD 12B PARK RIVER, ND 58270

(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 06/06/11 and completed on 06/09/11, the sample included 3 residents for complete review, 9 residents for focused review, and 1 closed record for review. The sample included 4 additional residents to verify specific concerns during the survey.	F 000	"Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State Law require it. For the purposes of any substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Center for Medicare and Medicaid.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, the facility failed to provide a meaningful weekend activity program to to meet the needs of 6 of 7 residents (Resident A, B, C, D, E, and F) attending the group interview and failed to provide activities designed to meet the resident's individual needs for 1 of 9 sampled residents (Resident #8) requiring assistance to attend activities. Failure to accommodate the needs and activity preferences of residents has the potential to negatively impact residents' psychosocial well-being. Findings include: - An interview with a group of residents occurred on 06/07/11 at 9:30 a.m. The facility identified all residents attending as interviewable. When asked	F 248	1. Resident #8's activity plan has been re-evaluated and care plan updated. More weekend activity opportunities have been added to the activity calendar. 2. Evaluate Activity Program of all present and future residents using GSS #145, Population Analysis Worksheet and update care plans as needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joan Olson — TITLE: Administrator — (X6) DATE: 7-12-11

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 248	Continued From page 1 about the activity program, Resident A, B, C, D, E, and F expressed concerns with the lack of activities on weekends. Resident A stated, "the weekends are long." The residents stated scheduled activities on Saturday are church and bingo and on Sunday the activity is church. Resident F stated, "Sometimes the minister doesn't come." The resident also stated there is no piano player, so residents are not able to sing hymns during the service. Review of the activity calendars for the months of April through June 2011 occurred on 06/08/11 at 2 p.m. with an activity staff member (#3). The calendars identified Saturday activities as Catholic Mass and a video of a Lutheran service at 9:30 a.m. and bingo at 2:30 p.m. The calendars identified Sunday activities in April and May as "Sunday Worship" at 2:30 p.m. and "TBA [to be announced]" at 4 p.m. The calendars identified special activities (such a Easter egg coloring) on one Saturday in April and on one Saturday and two Sundays in May. For June the the calendar identified the Sunday activity as "Sunday Worship" at 2:30 p.m. On June 5, 2011 the calendar stated "didn't come" for the Sunday Worship. When asked about weekend activities, the staff member (#3) stated activity staff work from 9 a.m. to 4:30 p.m. on Saturday and do not work on Sunday. She stated, prior to June 1, 2011, they worked from 1 p.m. to 5 p.m. on Sundays. The staff member stated staff usually provided games or crafts for the TBA activity on Saturday. When asked if there are times when minister does not come on Sunday, the staff member (#3) stated it occurred in the past, but does not happen as	F 248	3. Education for Activity Staff explaining various levels of the population analysis as they relate to activity programming and the importance of an activity program for providing activities to all residents. Training provided to Pastors on using the clavinova when organist is not available. 4. Activity Director or designee will complete audits weekly x two weeks, monthly x 3 months and then as deemed necessary by QA committee. 5. Completed July 15, 2011	

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F 248	Continued From page 2	F 248		

frequently now because activity staff call the ministers on Friday to remind them. She confirmed the minister did not come on June 5. She also confirmed no pianist is available on Sunday, since activity staff no longer work on Sunday.

An interview with an administrative activity staff member (#4) occurred on 06/09/11 at 7:50 a.m. regarding weekend activities. She stated ministers from several local churches alternate coming on Sundays. The staff member (#4) stated if there is no pianist available, staff can put a compact disc in the Clavinova (a digital piano). When asked, she stated activity staff know how to use the Clavinova, but have not educated nursing staff or ministers in its use.

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia with psychosis, depression, and anxiety. The annual Minimum Data Set (MDS), dated 01/13/11, identified Resident #8's activity preferences as reading, listening to music, being around animals, and participating in religious activities. Resident #8's current MDS, dated 04/13/11, identified short-term and long-term memory problems, rarely/never makes self understood or understands others, and continuously present inattention and disorganized thinking. The current care plan, dated 04/20/11, stated the following related to activities, ". . . Plans and Approaches . . . Encourage to look at magazines and picture cook books, flowers . . . Remind and invite to activities Sunday worship and baking, exercises, hymn sing, parties, programs . . . Provide 1:1 visits and socialization, interests: family, baking, local news, church . . .

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F 248	Continued From page 3 Target activities: exercises, music, baking, Park River, family . . ." Observations of Resident #8 occurred throughout the survey and included the following: *06/06/11 at 2:00 p.m.: asleep in her wheelchair in the hallway *06/06/11 at 4:32, 5:15, and 5:50 p.m.: self-propelling in her wheelchair in the hallway *06/07/11 at 8:59 a.m.: asleep in bed *06/07/11 at 11:31 a.m.: assisted from bed to the tub room per two certified nursing assistants (CNAs) *06/07/11 at 12:50 p.m.: eating lunch in the dining room *06/07/11 at 1:40 p.m.: asleep in her wheelchair in the TV area *06/07/11 at 3:20 p.m.: asleep in her wheelchair in the TV area. A staff member asked the resident if she would like to attend the music program. The staff member brought the resident half way down the hall but then left to assist another CNA. Observation showed Resident #8 asleep in her wheelchair in the hallway until 4:36 p.m. when two CNAs took her to the bathroom. *06/08/11 at 8:50 and 9:28 a.m.: asleep in her wheelchair in the TV area *06/08/11 at 10:40 a.m.: asleep under the hair dryer in the beauty shop *06/08/11 at 11:15 a.m.: asleep in her wheelchair in the TV area, at 11:48 a CNA brought Resident #8 to the dining room for lunch *06/08/11 at 12:59 p.m.: Two CNAs took Resident #8 to the bathroom and assisted her to lie down *06/08/11 at 2:30 p.m.: Asleep in her wheelchair in the TV area *06/08/11 at 3:10 p.m.: A staff member gave	F 248		

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F 248	Continued From page 4 Resident #8 some juice *06/08/11 at 3:45 p.m.: Asleep in her wheelchair in the TV area *06/08/11 at 4:15 p.m.: Two CNAs took Resident #8 to the bathroom and then brought her to the TV area, observation a few minutes later showed the resident asleep in her wheelchair The activity calendar for June 6, 7, and 8, 2011, identified devotions every day, baking on June 6, hymn sing on June 7, and exercise on June 8. Resident #8's care plan identified these as "target activities"; however, observation showed staff failed to ensure Resident #8 attended any of these activities. Review of Resident #8's activity participation logs showed R.O. (reality orientation) as a frequent activity. During an interview on the morning of 06/09/11, an activities staff member (#4) stated reality orientation involves the staff introducing themselves to the resident, telling them what day and month it is, and "things like that."	F 248		
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272		

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F 272	Continued From page 5 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the Care Area Assessments (CAAs) for 2 of 2 sampled residents (Resident #1 and #4), 1 closed record (Resident #13) and 4 supplemental residents (Resident #14, #15, #16, and #17) with annual Minimum Data Sets (MDSs) completed in October 2010. Failure to complete the CAAs could result in resident care plans not addressing all triggered areas for the residents.	F 272	1. Care Area Assessments (CAA) was completed on February 2, 2011 for Resident #1 with the next comprehensive assessment. CAAs were completed on January 26, 2011 with the next comprehensive assessment for Resident #14. CAAs were completed on March 31, 2011 with the next comprehensive assessment for Resident #17. CAAs will be completed with the next comprehensive assessments for Resident # 4 and #15. Resident #13 was a closed record. 2. All residents with comprehensive assessments had the potential to be affected. 3. Staff education was provided November 2010 to correct this practice. 4. Unit Coordinators, Director of Nursing, QA Coordinator or others as assigned will complete audits of the comprehensive assessments monthly x one month and then as deemed necessary by the QA committee. 5. Completed July 15, 2011	

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F 272	Continued From page 6 Findings include: - Resident #4's medical record, reviewed June 6-8, 2011, identified an admission MDS, dated 07/31/10, and an annual MDS, dated 10/16/10. Review of the 10/16/10 assessment identified the facility failed to complete the CAAs triggered for the annual assessment. During an interview on 06/07/11 at 11:50 a.m. two administrative nurses (#2 and #6) confirmed staff did not complete the CAAs for the triggered areas for Resident #4's October 2010 annual comprehensive assessment. They stated staff did not complete the CAAs for the October assessment because they completed a comprehensive assessment in July 2010 and the CAAs "were not due." Review of the following residents' medical records identified comprehensive MDSs completed in October 2010: Resident #1- Annual MDS 10/26/10 Resident #13 - Annual MDS 10/22/10 Resident #14 - Annual MDS 10/21/10 Resident #15 - Annual MDS 10/19/10 Resident #16 - Annual MDS 10/24/10 Resident #17 - Annual MDS 10/16/10 Staff failed to complete the CAAs for the above residents for all triggered areas on the MDSs. Failure to complete further assessment of the triggered areas could result in incomplete care planning of those care areas for the residents.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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F 278	Continued From page 7 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the residents' status for 2 of 4 sampled residents (Resident #1 and #8) identified with a toileting plan. Failure to accurately assess residents and	F 278	1. Bowel and bladder assessments were initiated on July 7, 2011 for Residents #1 and #8. Individualized care plans were developed from the assessments. 2. A query was run to identify all residents having a bowel or bladder program scored on the Minimum Data Set (MDS) who have the potential to be affected. 3. Unit Coordinators reviewed the coding of the MDS in Section H of the Resident Assessment Instrument (RAI) manual and the "Toileting Program" procedure II.B.10h in the Good Samaritan Society Nursing Services Manual. All residents scored on the MDS as having a toileting plan will be reviewed for assessments and individualized care plans. 4. Unit Coordinators, Director of Nursing, QA Coordinator or others as assigned will complete audits monthly x 3 months and then as deemed necessary by the QA committee. 5. Completed July 15, 2011	

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F 278	Continued From page 8 code the MDS accordingly may affect the level of care provided to the residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding toileting programs in the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, dated 07/10, page H-6, which states "Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated, and is consistent with the nursing home's policies and procedures and current standards of practice. . . ." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia with psychosis, depression, and anxiety. Resident #8's MDSs; dated 04/13/11, 01/13/11, 10/14/10, and 07/14/10, identified frequent urinary incontinence and a scheduled toileting program. Resident #8's care plan, dated 04/20/11, stated the following, ". . . Problems . . . Frequent bladder & bowel incontinence . . . Plans and Approaches . . . AM, PM, HS [hour of sleep] toilet schedule . . ." A previous care plan, dated 07/21/10, identified the same toileting schedule. Facility staff failed to complete a bladder or toileting assessment for this resident. During an interview on 06/09/11 at 9:15 a.m., a nursing supervisor (#2) agreed that a.m., p.m., and HS were not individualized toileting times. She also stated they had not completed a recent	F 278		

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F 278	Continued From page 9 toileting/bladder assessments for Resident #8. - Review of Resident #1's record occurred on all days of survey. Diagnoses included dementia with psychoses, bipolar disorder, depression, and constipation. The resident's most recent MDS, dated 04/26/11, identified a urine and bowel toileting program. Resident #1's current careplan, undated, identified a toileting schedule of noc (night), AM (morning), PM (evening), and before and after meals. The facility failed to complete a recent bladder and bowel assessment.	F 278		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents (gait belts, wheelchair foot pedals) for 5 of 10 residents (Resident #1, #4, #5, #8, and #9) requiring staff assistance with transfers and locomotion. Failure to use gait belts and wheelchair foot pedals has the potential to result in avoidable falls and/or injuries to the residents.	F 323	1. Education was provided immediately for use of gait belts when transferring Resident #1, #4, #5, and #8. Also for the use of leg rest for resident #8 and #9. A carry bag was applied to the back of the wheelchair for Resident #8. The leg rests are then removed from the bag and applied to the wheelchair for staff-assisted transport. Leg rests were immediately applied to Resident #9's wheelchair. 2. A query was run to identify residents requiring transfer support. Of this list, all residents not care planned to use a mechanical lift have the potential to be affected by not using gait belts. All residents in wheelchairs have the potential to be affected.	

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F 323	Continued From page 10 Findings include: Review of the facility policy titled "Gait (Transfer) Belt" occurred on 06/09/11. This policy, revised January 2009, stated, ". . . Purpose . . . To safely transfer or ambulate resident . . . To avoid injury to both resident and staff member . . . NOTE: Gait belts used unless medically contraindicated . . . Procedure . . . 4. Make sure belt is securely buckled so it does not slide. Belt should not be twisted and should be just snug enough so you can get your fingers under it. . . ." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia with psychosis, chronic dizziness, and a history of falls. The resident's current Minimum Data Set (MDS), dated 04/13/11, identified short-term and long-term memory impairment, severely impaired decision making skills, and required extensive assistance of two or more persons with transfers. Resident #8's care plan, dated 04/20/11, stated, ". . . Problems . . . Mobility deficit . . . assist with transfers & mobility . . . hx [history of] & risk for falls . . . Plans and Approaches . . . Transfer [with] assist [one to two] . . . W/C [wheelchair] for distance, propels per self or staff assist . . ." A random observation on the afternoon of 06/06/11 showed an unidentified CNA pushed Resident #8 down the hallway in a wheelchair. The resident's wheelchair did not have foot pedals, and her feet brushed along the floor. Observation on 06/07/11 at 11:31 a.m. showed two certified nursing assistants (CNAs) (#12 and	F 323	3. Education was provided on use of gait belts and foot pedals at nursing staff in-service. Carry bags will be placed on wheelchairs as needed for storage of foot pedals. 4. Rehabilitation Coordinator, QA Coordinator or designee will completed audits weekly x 2 weeks, then monthly x 3 months, then as deemed necessary by the QA committee. 5. Completed July 15, 2011.	

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#13) assisted Resident #8 to sit on the edge of the bed. The CNAs failed to apply a gait belt and pivot-transferred the resident to a bath chair by lifting her under the arms. Observation showed Resident #8 stood on her tip-toes and staff drug her feet across the floor during the transfer.

Observation on 06/07/11 at 12:20 p.m. showed Resident #8 seated in a wheelchair with her feet on the floor. An unidentified staff member pushed the resident from the chapel into the dining room with the resident's feet dragging on the floor.

Observation on 06/07/11 at 1:56 p.m. showed a CNA (#8) pushed Resident #8 down the hallway in a wheelchair. The resident's heels caught and skipped across the floor. The CNA stopped pushing the resident and asked, "Can you lift your feet, [Resident name]?" Observation showed the resident briefly lifted her feet, but let them drop again after the CNA resumed pushing her wheelchair. Resident #8's heels once again caught on the floor, and the resident stated, "Ouch!" The CNA stated, "I'm sorry." Observation showed Resident #8's heels continued to brush across the floor from the resident's room, down the hallway, and into the TV area.

Observation on 06/07/11 at 4:36 p.m. showed two CNAs (#10 and #14) transferred Resident #8 to the toilet. To assist the resident to stand, the CNAs lifted her under the arms and grabbed the waistband of her pants. They pivoted the resident onto the toilet and failed to use a gait belt during the transfer. Upon completion of toileting, the CNA (#10) transported Resident #8 to the TV area in her wheelchair without the use of foot pedals. Observation showed the resident's feet

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	355089	A. BUILDING _____ B. WING _____	06/09/2011

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GOOD SAMARITAN SOCIETY - PARK RIVER	301 COUNTY RD 12B PARK RIVER, ND 58270

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F 323	Continued From page 12 brushed along the floor during the transfer. Observation on 06/08/11 at 11:48 a.m. showed a CNA (#8) transported Resident #8 from the TV area to the dining room in her wheelchair. The resident's feet brushed along the floor during the transfer. During an interview on the morning of 06/09/11, a nursing supervisor (#7) agreed staff should use a gait belt when transferring Resident #8 because "she has weakness." Observation on 06/07/11 at 10:30 a.m. showed a CNA (#11) pushed Resident #9 in her wheelchair from the dining room to her room without the use of foot pedals. The CNA stated, "Pick up your feet," and observation showed the resident's feet dragging along the floor. During an interview on the morning of 06/09/11, a nursing supervisor (#2) stated she would expect staff to use wheelchair foot pedals during staff-assisted wheelchair transfers. - Resident #5's medical record, reviewed June 6-8, 2011, identified diagnoses including degenerative joint disease. An admission Minimum Data Set (MDS), dated 05/23/11, identified Resident #5 required extensive assistance of two or more persons with transfers. Observation on 06/07/11 at 8:07 a.m. identified a CNA (#3) assisted Resident #5 from her bed to her wheelchair. The CNA held the resident's arm as she transferred her to the wheelchair. The CNA failed to use a gait belt during the transfer.	F 323		

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F 323	Continued From page 13 On 06/07/11 at 8:45 a.m., observation showed the CNA (#3) assisted Resident #5 back to bed. The CNA assisted Resident #5 without a gait belt, holding her arm during the transfer. - Resident #4's medical record, reviewed June 6-8, 2011, identified diagnoses including degenerative joint disease, osteoporosis, and chronic low back pain. A quarterly MDS, dated 04/16/11, identified Resident #4 required extensive assistance of one person with transfers and limited assistance of one person with walking in the room. The resident's care plan, dated 04/26/11, identified a problem, "Mobility deficit R/T HX of fractures, CAD [coronary artery disease], M/B need for walker and w/c [wheel chair], degenerative changes noted to hands H/O [history of] osteoporosis." Approaches to the problem included "w/c for distances staff propel, walker in room." On 06/07/11 at 10:45 a.m., observation identified a CNA (#3) assisted Resident #4 to stand and ambulate with a walker into the bathroom. The resident held the safety bars in the bathroom to assist with sitting on the toilet. The CNA provided stand by assistance and did not use a gait belt when assisting Resident #4 into the bathroom. After toileting, the CNA assisted Resident #4 to ambulate from the bathroom to her chair (across the room from the bathroom). Resident #4 held her walker and the CNA held the resident's arm while she walked across the room. Observation showed the resident ambulated slowly, with her knees slightly bent and turned inward while she ambulated. As the resident neared her chair, her legs began to tremble. Resident #4 hesitated and	F 323		

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F 323	Continued From page 14 attempted to sit before she reached the chair. The CNA (#3) cued Resident #4 to get closer to the chair before sitting. The CNA failed to use a gait belt while ambulating Resident #4. During an interview on 06/08/11 at 5:40 p.m. an administrative nurse (#6) stated she expects staff to use gait belts when assisting residents with transfers and/or ambulation. When interviewed, on 06/09/11 at 8:30 a.m., a rehabilitation nurse (#7) stated she would expect staff to use a gait belt with transfers for Resident #5. She stated Resident #4's ability to ambulate "varies." The nurse stated sometimes she does well, but it "depends on her arthritis." - Resident #1's medical record, reviewed June 06-09, 2011, indicated diagnoses including dementia with psychoses, osteoporosis, and pain. Observation on 06/07/11 at 9:15 a.m., showed a CNA (#8) transferred Resident #1 from the bed to a wheelchair. The CNA loosely applied a gait belt around the resident, but failed to tighten the gait belt. The gait belt slid up under the resident's axilla during the transfer. Observation on 06/07/11 at 10:27 a.m., showed a CNA (#8) transferred Resident #1 from a wheelchair into a bed. The CNA loosely applied a gait belt around the resident, but failed to tighten and secure the belt around the resident's body. The gait belt slid up under the resident's axilla during the transfer.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 15 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of policy/procedure, review of professional	F 431	1. The filing cabinet containing the controlled medications for disposal storage box was immediately locked. PRN medications were reordered with the dispensed and expiration dates on the label. 2. All residents receiving prescription medications have the potential to be affected. 3. A double-locked box has been put into service for discontinued narcotics. The pharmacist and surveyor discussed the need for expiration dates on the dispensed medications. 4. Administrator, Director of Nursing, QA Coordinator or designee will audit weekly x 2 weeks, monthly x 1 month, then as QA committee deems necessary. 5. Completed July 15, 2011.	

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F 431	Continued From page 16 standards, and staff interview, the facility failed to ensure all narcotics were maintained in appropriately locked areas and only authorized personnel had access to the medications for 1 of 1 controlled medications for disposal storage area. Failure to properly store and limit access to prescription narcotic medications has the potential for unauthorized entry, and misappropriation of medications with a high potential for abuse. Findings include: Review of facility policy titled, "Disposition of Medications", occurred on 06/09/11. This policy, revised 03/2011, stated, ". . . 3. Scheduled drugs which have been discontinued should be placed in a locked box in the director of nursing service's (DNS) office as soon as they have been discontinued. A count of these medications should be reconciled before they are destroyed. Keys to this box should only be held by the DNS and the administrator. . . ." On 06/08/11 at 4:30 p.m. observation showed the door to the administrative nursing staff's (#2) office open and unattended. The staff member (#2) entered the office and upon request of the surveyor, retrieved a set of keys from an unlocked drawer in her desk, opened an unlocked bottom drawer of a filing cabinet, and unlocked a box containing narcotics for disposal. The box contained 14 tablets of Oxycodone/APAP 5-325 milligrams (mg) (Schedule II) and two patches of Fentanyl Transdermal 5 micrograms per hour (mcg/h) (Schedule II).	F 431		

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F 431	Continued From page 17 Multiple random observations throughout the survey showed the door to the DNS's office open with no staff present. An interview with the staff member (#2) occurred immediately following the observation on 06/08/11 at 4:30 p.m. The staff member agreed the filing cabinet should have been locked and the keys secured. 2. Based on observation, review of professional standards, and staff interview, the facility failed to ensure appropriate labeling of medications with expiration dates for 2 of 2 medication carts. This practice has the potential for all residents receiving prescription medications to receive expired medications. Findings include: Observation on the afternoon of 06/08/11, showed two medication carts containing the following medications without dispensed dates or expiration dates: * 3 cards of Hydrocodone/APAP * 1 card of Vistaril * 7 cards of Ativan * 2 cards of Alprazolam * 1 card of Trazodone * 3 cards of Tramadol * 1 card of Oxycodone * 1 card of Epidrin An interview with a pharmacist (#9) occurred the afternoon of 06/08/11. The pharmacist agreed medications should be labeled with an expiration date.	F 431		

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