Oklahoma State Department of Health
Creating a State of Health

July 30, 2019

License Number: NH7211AL

Ms. Dinah Donley, Administrator
Franciscan Villa
17110 E 51 St Street
Broken Arrow, OK 74012

RE: Survey Event ID: VI1U11

Dear Ms. Donley:

On **July 10, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on July 10, 2019.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;

(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

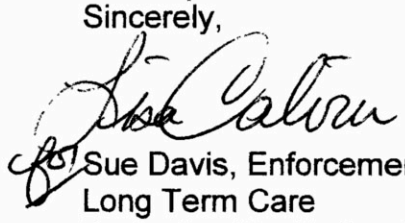
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,



Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH7211AL	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN VILLA	17110 E 51 ST STREET BROKEN ARROW, OK 74012

(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) COMPLETE DATE
N 000	Initial Comments A re-licensure survey was conducted 07/08/19 through 07/10/19. Resident census was 41. The following deficient practices were cited.	N 000		
N1105 SS=F	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a performance review was completed annually for 3 (#4, 5 and #6) of 4 sampled long term care aides (LTCA) that had been employed by the center for at least one year. This failed practice had the widespread potential for more than minimal harm. Findings: On 07/08/19 at 2:45 p.m., the employee files were reviewed. The files for LTCA (long term	N1105		

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N1105	Continued From page 1 care aide)/employees #4 (hired 09/27/17), #5 (hired 11/05/08) and #6 (hired 07/02/18) did not include a skills review. At 4:30 p.m., the activity director and the administrator looked through the employee files and stated LTCA/employees #4, 5 and #6 did not have documentation their long term care aide skills had been reviewed. On 07/09/19 at 1:30 p.m., LTCA #4 stated she had never had her long term care aide skills verified since she had been employed by the center on 09/27/17.	N1105		

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A re-licensure survey was conducted 07/08/19 through 07/10/19. Resident census was 41. The following deficient practices were cited.	C 000		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure an admission assessment had been completed within 30 days of admission, or at the time of admission, for 1 (#2) of 2 sampled residents who had been admitted to the center since the last survey. This had the isolated potential for more than minimal harm. Findings: Resident #2 was admitted to the center 07/02/19. Her record included an assessment that was not dated, was not completed and did not specify what type of assessment it was. No other assessments were included in the resident's record. On 07/09/19 at 4:10 p.m., the RN (registered nurse) looked at the assessment and stated it could not be an admission assessment since it was not dated, was not completed and did not specify what type of assessment it was. She said since no other assessments were included in the	C 521		

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C 521	Continued From page 1 resident's record, the resident did not have an admission assessment.	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a comprehensive assessment was completed annually or after a significant change in condition for 3 (#1, 3 and #7) of 6 sampled residents. This failed practice had the potential for more than minimal harm, at a pattern. Findings: Resident #1 Resident #1 was admitted to the center 05/20/17. The last comprehensive assessment included in her record was dated 06/20/18.	C 522		

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C 522	Continued From page 2 On 07/10/19 at 9:45 a.m., LPN (licensed practical nurse) #1 stated the resident did not have a comprehensive assessment completed annually. Resident #3 Resident #3 was admitted to the center 01/07/07. Her most recent comprehensive assessment was dated 01/28/19. The assessment documented the resident was alert and fully oriented, was independent with personal care and was continent except for occasional stress incontinence. On 07/08/19 a report on the residents was received from the RN (registered nurse) and a direct care staff. Both employees stated the resident had experienced a decline in condition and was now fully incontinent of both bowel and bladder. On 07/10/19 at 10:00 a.m., the resident was asked the year. She was unable to say the year and could not even guess. She could not provide a coherent answer when asked how long she had lived in the center. She stated she was totally independent and required no assistance from the staff for personal care. At 10:20 a.m., LTCA (long term care aide)/employee #4 stated the resident was no longer independent with personal care as she required reminders and cueing, was totally incontinent of both bowel and bladder and was no longer fully oriented. At 10:30 a.m., LPN #1 stated the resident should have had a significant change assessment completed because she had a change in	C 522		

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C 522	Continued From page 3 condition. Resident #7 Resident #7 was admitted to the center 04/09/16. The most recent comprehensive assessment included in the resident's record was dated 05/09/18. On 07/10/19 at 9:45 a.m., LPN (licensed practical nurse) #1 stated the resident did not have a comprehensive assessment completed annually.	C 522		
C 954 SS=F	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure 2 (#3 and #4) of 7 sampled direct care staff were trained in first aid. This failed practice had the widespread potential for more than minimal harm. Findings: On 07/08/19 at 2:45 p.m., the employee files were reviewed. The files for LTCA (long term care aide)/employee #3 and LTCA/employee #4 did not include documentation of training in first aid. At 4:30 p.m., the activity director and the administrator looked through the employee files	C 954		

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C 954	Continued From page 4 and stated LTCA/employees #3 and #4 did not have documentation they had been trained in first aid. On 07/09/19 at 1:30 p.m., LTCA/employee #4 stated she had not had training in first aid.	C 954		
C1923 SS=F	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to maintain an accurate written record to include the identity and signature of the persons administering medications for 4 (#5, 6, 7, and #8) of 4 sampled residents who were administered medications by the center's staff. This failed practice had the	C1923		

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C1923	Continued From page 5 potential for more than minimal harm, at a pattern. Findings: On 07/09/19, the MARs (medication administration records) for residents #5, 6, 7 and #8 were reviewed. The MARs did not include signatures or printed names of the center's staff who administered medications to the residents, just their electronic initials. On 07/10/19 at 11:30 a.m., the administrator stated, to her knowledge, the center did not maintain a master list of signatures and initials, so initials could be matched to a signature to identify who gave medications. At 11:40 a.m., CMAs (certified medication aide) #4, 7 and #8 stated the center did not maintain a master list of signatures and initials. They all stated they just electronically signed the medications they administered with their initials and they did not go back and sign and initial the MARs after they were printed out.	C1923		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
NH7211AL	FRANCISCAN VILLA

Type of Survey (select all that apply)

2				

A Complaint Investigation
B *Dumping Investigation*
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F *Inspection of Care*
G Validation
H Life Safety Code
I Recertification
J *Sanctions/Hearing*
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 36967	07/08/2019	07/10/2019	0.25	0.00	17.25	0.00	6.00	3.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

JUL 31 2019 jm

Oklahoma State Department of Health
Creating a State of Health

August 15, 2019

License Number: NH7211AL

Ms. Dinah Donley, Administrator
Franciscan Villa
17110 E 51 St Street
Broken Arrow, OK 74012

RE: Survey Event VI1U11

Dear Ms. Donley:

On July 10, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 31, 2019**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/jt

Oklahoma State Department of Health

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N 000	Initial Comments A re-licensure survey was conducted 07/08/19 through 07/10/19. Resident census was 41. The following deficient practices were cited.	N 000		
N1105 SS=F	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a performance review was completed annually for 3 (#4, 5 and #6) of 4 sampled long term care aides (LTCA) that had been employed by the center for at least one year. This failed practice had the widespread potential for more than minimal harm. Findings: On 07/08/19 at 2:45 p.m., the employee files were reviewed. The files for LTCA (long term	N1105	Employee's #4, #5 & #6 have received the required performance review. All residents have the potential to be affected by this alleged deficient practice. Appropriate staff was in-serviced regarding the requirements of annual performance reviews. All nurse aide files have been audited and anyone not having the required performance review was completed. A notebook with copies of performance reviews were implemented to track when reviews are due. Audits will be submitted to the QA committee for review to ensure compliance. Any issues will be documented and immediately corrected. The QA comittee will continue to review for a period of 6 months to ensure substantial compliance continues.	8/31/2019

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dinah Donley — TITLE: Administrator — (X6) DATE: 8/6/19

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N1105	Continued From page 1 care aide)/employees #4 (hired 09/27/17), #5 (hired 11/05/08) and #6 (hired 07/02/18) did not include a skills review. At 4:30 p.m., the activity director and the administrator looked through the employee files and stated LTCA/employees #4, 5 and #6 did not have documentation their long term care aide skills had been reviewed. On 07/09/19 at 1:30 p.m., LTCA #4 stated she had never had her long term care aide skills verified since she had been employed by the center on 09/27/17.	N1105		
C 000	INITIAL COMMENTS A re-licensure survey was conducted 07/08/19 through 07/10/19. Resident census was 41. The following deficient practices were cited.	C 000		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES *(a) The assisted living center shall complete the* admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure an admission assessment had been completed within 30 days of admission, or at the time of admission, for 1 (#2) of 2 sampled residents who	C 521	Resident #2 has received a current assessment. All new residents admitted to the assisted living *center have the potential to be affected by this* alleged deficient practice. Appropriate staff have been In-serviced regarding the requirements of completing admission assessments. All current residents records have been audited and updated assessments have been completed. A copy of current assessments will be placed in a notebook for tracking purposes. Audits will be submitted to the QA committee for review to ensure compliance. Any issues will be documented and immediately corrected. The QA committee will continue to review for a period of 6 months to ensure substantial compliance continues.	8/31/2019

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C 521	Continued From page 2 had been admitted to the center since the last survey. This had the isolated potential for more than minimal harm. Findings: Resident #2 was admitted to the center 07/02/19. Her record included an assessment that was not dated, was not completed and did not specify what type of assessment it was. No other assessments were included in the resident's record. On 07/09/19 at 4:10 p.m., the RN (registered nurse) looked at the assessment and stated it could not be an admission assessment since it was not dated, was not completed and did not specify what type of assessment it was. She said since no other assessments were included in the resident's record, the resident did not have an admission assessment.	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition.	C 522	Residents #1, #3 & #7 have received an updated assessment. All residents residing in the assisted living center have the potential to be affected by this alleged deficient practice. Appropriate staff have been In-serviced regarding the requirements of completing comprehenisve assessments including significant changes. All current residents records have been audited and updated assessments have been completed. A copy of current assessments will be placed in a notebook for tracking purposes. Audits will be submitted to the QA committee for review to ensure compliance. Any issues will be documented and immediately corrected. The QA committee will continue to review for a period of 6 months to ensure substantial compliance continues.	8/31/2019

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	NH7211AL	A. BUILDING: _____ B. WING _____	07/10/2019

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C 522	Continued From page 3 *This Rule is not met as evidenced by:* Based on interview and record review, it was determined the center failed to ensure a comprehensive assessment was completed annually or after a significant change in condition for 3 (#1, 3 and #7) of 6 sampled residents. This failed practice had the potential for more than minimal harm, at a pattern. Findings: Resident #1 Resident #1 was admitted to the center 05/20/17. The last comprehensive assessment included in her record was dated 06/20/18. On 07/10/19 at 9:45 a.m., LPN (licensed practical nurse) #1 stated the resident did not have a comprehensive assessment completed annually. Resident #3 Resident #3 was admitted to the center 01/07/07. Her most recent comprehensive assessment was dated 01/28/19. The assessment documented the resident was alert and fully oriented, was independent with personal care and was continent except for occasional stress incontinence. On 07/08/19 a report on the residents was received from the RN (registered nurse) and a direct care staff. Both employees stated the resident had experienced a decline in condition and was now fully incontinent of both bowel and bladder. On 07/10/19 at 10:00 a.m., the resident was	C 522		

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C 522	Continued From page 4 asked the year. She was unable to say the year and could not even guess. She could not provide a coherent answer when asked how long she had lived in the center. She stated she was totally independent and required no assistance from the staff for personal care. At 10:20 a.m., LTCA (long term care aide)/employee #4 stated the resident was no longer independent with personal care as she required reminders and cueing, was totally incontinent of both bowel and bladder and was no longer fully oriented. At 10:30 a.m., LPN #1 stated the resident should have had a significant change assessment completed because she had a change in condition. Resident #7 Resident #7 was admitted to the center 04/09/16. The most recent comprehensive assessment included in the resident's record was dated 05/09/18. On 07/10/19 at 9:45 a.m., LPN (licensed practical nurse) #1 stated the resident did not have a comprehensive assessment completed annually.	C 522		
C 954 SS=F	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.	C 954		

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C 954	Continued From page 5 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure 2 (#3 and #4) of 7 sampled direct care staff were trained in first aid. This failed practice had the widespread potential for more than minimal harm. Findings: On 07/08/19 at 2:45 p.m., the employee files were reviewed. The files for LTCA (long term care aide)/employee #3 and LTCA/employee #4 did not include documentation of training in first aid. At 4:30 p.m., the activity director and the administrator looked through the employee files and stated LTCA/employees #3 and #4 did not have documentation they had been trained in first aid. On 07/09/19 at 1:30 p.m., LTCA/employee #4 stated she had not had training in first aid.	C 954	Employees #3 & #7 have received current training on First Aid. All residents residing in the assisted living center have the potential to be affected by this alledged deficient practice. Appropriate staff have been In-serviced regarding the requirements of First Aid training for staff. An audit was completed on all direct care employee files. Any direct care employee that didn't have current First Aid training was completed. A spreadsheet has been implemented to track completion of required training. Audits will be submitted to the QA committee for review to ensure compliance. Any issues will be documented and immediately corrected. The QA committee will continue to review for a period of 6 months to ensure substantial compliance continues.	8/31/2019
C1923 SS=F	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results.	C1923	Residents #5, #6, #7 & #8 medication records were updated to show signature identifying staff member administering medications. All residents residing in the assisted living center have the potential to be affected by this alleged deficient practice. Appropriate staff was In-serviced regarding the requirements of identification of staff including signature when administering medications. Audits were completed to ensure all resident's medication records had the required signature of staff member administering the medication. Audits will be submitted to the QA committee for review to ensure compliance. Any issues will be documented and immediately corrected. The QA committee will continue to review for a period of 6 months to ensure substantial compliance continues.	8/31/2019

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C1923	Continued From page 6 (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to maintain an accurate written record to include the identity and signature of the persons administering medications for 4 (#5, 6, 7, and #8) of 4 sampled residents who were administered medications by the center's staff. This failed practice had the potential for more than minimal harm, at a pattern. Findings: On 07/09/19. the MARs (medication administration records) for residents #5, 6, 7 and #8 were reviewed. The MARs did not include signatures or printed names of the center's staff who administered medications to the residents, just their electronic initials. On 07/10/19 at 11:30 a.m., the administrator stated, to her knowledge, the center did not maintain a master list of signatures and initials, so initials could be matched to a signature to identify who gave medications. At 11:40 a.m., CMAs (certified medication aide) #4, 7 and #8 stated the center did not maintain a master list of signatures and initials. They all stated they just electronically signed the medications they administered with their initials and they did not go back and sign and initial the MARs after they were printed out.	C1923		

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