



Oklahoma State Department of Health
Creating a State of Health

July 23, 2019

License Number: RC7303
Survey Event ID: N1J211

Ms. Elizabeth Chapman, Administrator
Wagoner Care Center Res. Care
205 North Lincoln
Wagoner, OK 74467

Dear Ms. Chapman:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey at your facility on **June 27, 2019**.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies.

Please note the items listed in the deficiency column of the report. Your plan of correction and anticipated date of completion must be typed in the space provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

- (1) A statement of exactly how the facility has or intends to correct each deficiency.
- (2) The method of correction. This includes who is responsible for the correction.
- (3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- (4) A reasonable date of correction, which will normally be within 30 days of this notice.

NOTE: Please avoid naming individuals, business firms or brand names on the enclosed form since it is a public disclosure form.

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **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 this completed form for your files.

In the event that we find your Plan of Correction unacceptable, you will be notified of the reason(s) it is not acceptable and we will request another Plan of Correction. If your plan of correction is acceptable, there will be no acknowledgement. We will conduct a revisit in accordance with your stated correction dates. If you have any questions concerning this letter, please contact me at (405) 271-6868.

Board of Health

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Interim Commissioner of Health

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In accordance with O.S. 63 830.1, 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 833-RC). 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 833RC and the Oklahoma IDR Process Residential Care Centers.

The IDR request must be submitted within 30 calendar days from receipt of the State Form deficiency statement. 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.

Sincerely,


Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC7303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/27/2019
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NAME OF PROVIDER OR SUPPLIER WAGONER HEALTH & REHAB RES CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 205 NORTH LINCOLN WAGONER, OK 74467
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(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 on 06/25/19 through 06/27/19. Current census was 10. The following deficiencies 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 two hours of in-service training supervised by a registered nurse was provided monthly for 2 (#1 and #4) of 2 long term care aides (LTCA) who provided direct resident care. This failed practice had the potential for more than minimal harm at a pattern for all 12 residents. Findings: On 06/26/19 at 4:00 p.m., the employees' in-service training records were reviewed and	N1105		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N1105	Continued From page 1 there was no start and stop times documented to determine the lengths of each in-service, nor was there a documented name of the person who provided the in-services. At 4:09 p.m. LTCA/MAT (medication administration employee)/employee #1 stated she had provided each of the in-services. At 6:00 p.m., the administrator stated a registered nurse had not supervised any of the in-services provided to the LTCA employees.	N1105		
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure certified medication aide (CMA) skills were validated prior to administering medication for 1 (#4) of 1 CMA who had been hired within the past year. This had the widespread potential for more than minimal harm for all 10 residents. Findings: On 06/26/19 at 3:43 p.m., the file for CMA #4 did not contain a medication skills checklist documented by a licensed nurse in her file.	N1442		

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N1442	Continued From page 2 At 11:50 a.m., long term care aide/medication administration technician (LTCA/MAT) stated she was the only person who had checked off LTCA/CMA #4's skills after she was hired to work double shifts on the weekends.	N1442		
R 000	INITIAL COMMENTS A re-licensure survey was conducted on 06/25/19 through 06/27/19. Current census was 10. The following deficiencies were cited.	R 000		
R 204 SS=F	310:680-3-3 (d) & (e)(1) INSPECTIONS, PHYSICIAN AND EMS SERVICES (d) An application for an initial license to operate a residential care home shall include documentation that the State Fire Marshal or the State Fire Marshal's representative has inspected and approved the home. Each application for renewal of a license for a residential care home with more than six beds shall include documentation of annual inspection and approval by the State Fire Marshal or the State Fire Marshal's representative. (e) The following items must be renewed annually: (1) An agreement with a physician to provide emergency medical services and consultation.	R 204		

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R 205	Continued From page 4 This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure an agreement with a pharmacist was renewed annually. This failed practice had the widespread potential for more than minimal harm for all 10 residents who received employee administered physician ordered medications. Findings: On 06/26/19 at 3:30 p.m., a review of agreements was conducted and the most current pharmacist's agreement was dated 01/01/17. At 4:56 p.m., the administrator #1 stated she had not obtained an agreement with the new pharmacy the home had begun to use.	R 205			
R 207 SS=F	310:680-3-3 (e)(4) ELECTRICIAN, MUNICIPAL INSPECTOR'S REPORT (e) The following items must be renewed annually: (4) Licensed electrician or municipal inspector's report. This Rule is not met as evidenced by: Based on interview and record review, it was	R 207			

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R 207	Continued From page 5 determined the home failed to ensure a licensed plumber or building inspector's report had been renewed annually. This failed practice had the widespread potential for more than minimal harm for all 10 residents. Findings: On 06/27/19 3:30 p.m., the most current plumbing inspection report found was dated 03/30/18. Long term care aide/medication administration aide stated the annual report had not been completed.	R 207		
R 220 SS=F	310:680-3-6 (b)(4) RETAINING A COPY OF OWNERSHIP (b) Every residential care home shall retain the following for public inspection: (4) A copy of the statement of ownership. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to ensure a copy of the statement of ownership was retained in the home and available for public inspection. This failed practice had the widespread potential for minimal harm for all 10 residents. Findings: On 06/27/19 at 3:10 p.m., both information boards had been observed and submitted manuals were reviewed for a copy of the statement of ownership. Nothing was found. The administrator stated she did not have one.	R 220		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WAGONER HEALTH & REHAB RES CARE

**205 NORTH LINCOLN
WAGONER, OK 74467**

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R 221	Continued From page 6	R 221		
R 221 SS=F	310:680-3-6 (b)(5) RETAINING A LIST OF PERSONNEL (b) Every residential care home shall retain the following for public inspection: (5) A list of personnel who are licensed, certified, or registered and employed or retained by the residential care home, including area in which individual is credentialed. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to retain a list of personnel who were licensed, certified, registered, and employed or retained by the home. This failed practice had the widespread potential for minimal harm for all 10 residents. Finding: On 06/25/19 at 3:15 p.m., information boards by the medication room door and on a wall by the dining by the were observed. No list of current personnel was found. long term care aide/medication administration technician (LTCA/MAT) was asked if a list of employed or retained personnel was available for inspection. She stated previously posted list had been taken down.	R 221		
R 225 SS=F	310:680-3-6 (e) EVACUATION PLAN AND FIRE DRILLS (e) An evacuation plan shall be developed and permanently displayed in the hallways and sitting room. Fire drills shall be conducted at least	R 225		

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R 225	Continued From page 7 quarterly. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure fire drills were conducted at least quarterly. This failed practice had the widespread potential for more than minimal harm for all 10 residents. Findings: On 06/25/19 at 3:11 p.m., long term care aide/medication administration technician/employee #1 was asked for the most recent fire drills. She stated, "We don't have them." She stated she did not know why, but she had not a had fire drill in the home. At 3:30 p.m., maintenance/employee #5 was asked for the past years fire drills. He submitted a manual, but there were no fire drills documented for the residential care home. He stated he had not conducted the required quarterly fire drills.	R 225		
R 317 SS=F	310:680-5-3 (d) MAXIMUM TEMPERATURE 85 F (d) Maximum temperature in all areas occupied by residents shall not exceed 85 degrees Fahrenheit, unless authorized or recommended by a physician. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure all areas of the home occupied by residents did not exceed 85 degrees Fahrenheit (F). This failed practice had the potential for more than minimal harm for	R 317		

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R 317	Continued From page 8 all 10. Findings: On 06/25/19 at 11:21 a.m., the ambient air temperature in the main entrance living room/nurses' desk area registered at 85.2 degrees F. Long term care aide/medication administration technician (LTCA/MAT)/employee #1 stated the air conditioner had not worked and the home had been hot for about one and one-half months. At 11:37 a.m., resident #1 stood at the front nurses' desk area while she retrieved snack crackers from a basket on the desk. She said she was warm there. At 11:41 a.m., maintenance/employee #5 also stated the air conditioner had not worked properly for about one and one-half months. At 2:27 p.m., the ambient air temperature registered at 87.5 degrees F near the main entrance nurses' desk area. Resident #7 walked in halls by front nurses' desk. At 4:35 p.m., the ambient air temperature registered at 88.2 degrees F near the main entrance nurses' desk area. Both LTCA/MAT/employee #1 and MAT/employee #2 stated it was too hot in that area. At 3:05 p.m., the ambient air temperature in the nurses' desk area registered at 87.4 degrees F.	R 317		
R 349 SS=F	310:680-7-1 CONTROL OF PREMISES The administrator shall have access to and authority over the entire premises. The person in charge shall be specifically designated in writing	R 349		

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R 349	Continued From page 9 by the administrator and shall have authority to act in his/her absence and have access to the home's records if the owner or operator is not immediately available. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the administrator failed to ensure the person in charge was specifically designated in writing. This failed practice had the widespread potential for more than minimal harm for all 10 residents. Findings: On 06/25/19 at 4:24 p.m., long term care aide/medication administration technician was asked if the person in charge had been designated in writing, to act in the administrator's absence. She stated, "I've never had anything in writing or posted." There was no person in charge document posted on either of the two (2) information boards, nor found in any of the submitted manuals.	R 349		
R 507 SS=F	310:680-11-1 (2)(B) STAFF QUALIFICATIONS - MEDICATION (2) Staff Qualifications. (B) All personnel who have the responsibility for administering or monitoring medication to residents shall obtain a certificate of training in medication administration from an institution of higher learning whose program has been reviewed by the Department. (Currently licensed physicians, registered nurses and licensed practical nurses shall be deemed to meet the medication administration training requirement.)	R 507		

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R 507	Continued From page 10 This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to ensure 1 (#3) of 5 employees who had the responsibility for administering medication was qualified and trained from an approved institution of higher learning. This failed practice had the widespread potential for more than minimal harm for all 10 residents who received employee administered physician ordered medications. Findings: On 06/26/19 at 3:34 p.m., the employees' files were review and revealed Department of Developmental Services medication administration technician (DDS MAT)/employee #3 was hired on 2/20/19. The sampled residents' June 2018 medication administration records documented DDS MAT/employee #3 administered their medications on the following dates: 06/01/19; 06/02/19; 06/08/19; 06/09/19; 06/14/19; 06/15/19;	R 507		

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R 507	Continued From page 11 06/16/19; 06/20/19; 06/22/19; and 06/23/19. At 4:18 p.m., DDS MAT/employee #3's file had a of Department of Human Services certificate that she was given for DDS Medication Administration Technician Training on 06/08/18. Long term care aide/medication administration technician (LTCA/MAT) was asked about DDS MAT/employee #3's training. She stated she did not know about the training due to DDS MAT/employee #3 had been hired in the nursing home next door. On 06/27/19 at 2:59 p.m., DDS MAT/employee #3 was observed on duty as she passed medications.	R 507		
R 510 SS=F	310:680-11-1 (3)(A) STAFF TRAINING - FIRST AID/CPR (3) In order to ensure all homes maintain a level of competency necessary to meet the needs of each individual served in the home, personnel must complete the following training requirements. (A) All employees shall be currently certified in first-aid and cardiopulmonary resuscitation (Red Cross training or equivalent). Proof of certification and training shall be kept on file in the home. First-Aid and CPR certificates shall be renewed annually, or as required to be kept current.	R 510		

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R 602	Continued From page 13 (1) Storage and Maintenance. (A) Medications shall be stored in an area that is locked, is well lighted, and room temperature not to exceed 86 degree Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure the residents' medications were stored in a room temperature that did not exceed 86 degrees Fahrenheit (F). This failed practice had the widespread potential of more than minimal harm for all 10 residents who received employee administered physician ordered medications. Findings: On 06/25/19 at 4:35 p.m., the ambient air temperature registered at 88.2 degrees F near the main entrance nurses' desk area. Both LTCA/MAT/employee #1 and MAT/employee #2 stated it was too hot in that area. The medication cart was still parked in its normal space, an enclosure in the wall by the medication room door. On 06/26/19 at 9:07 a.m., the medication room door was opened and it was very warm in there. The ambient air temperature in there registered at 88 degrees F on a thermometer on a wall. At 9:27 a.m., the administrator stated the home's pharmacist verbalized to her the residents' medications in the medication room would need to be replaced.	R 602		

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R 602	Continued From page 14 At 3:05 p.m., the ambient air temperature in the medication room registered at 90 degrees F. The ambient air temperature in the nurses' desk area near the medicaiton cart registered at 87.4 degrees F. On 06/27/19 at 8:57 a.m., the ambient air temperature in the medication room registered at 88 degrees F on the wall thermometer. Many of the medications in that room had labels that documented the medications should be stored at 68 to 77 degrees F.	R 602		
R 622 SS=F	310:680-13-1 (1)(U) MEDICATIONS - DISCONTINUED Correct medication and pharmacy techniques and principles shall be used when medications are administered or monitored. The home shall comply with the following: (1) Storage and Maintenance. (U) Discontinued medications may be kept up to three (3) months and must be separated from the current medications within the locked medication area. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to ensure discontinued medications were kept only up to three (3) months. This failed practice had the widespread potential for more than minimal	R 622		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER WAGONER HEALTH & REHAB RES CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 205 NORTH LINCOLN WAGONER, OK 74467		
(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
R 622	Continued From page 15 harm for all 10 residents. Findings: On 06/26/19 at 3:05 p.m., two shelves of medications were observed in the medication room with long term care aide/medication administration technician (LTCA/MAT)/employee #1. A medication destruction manual was reviewed and the last date documented for medication destruction was in October 2018. LTCA/MAT/employee #1 stated none of the discontinued medications on the shelved had been documented in the manual and no medications had been destroyed since October 2018 (8 months previous). When asked for the reason the discontinued medications were kept over the required 3 months, LTCA/MAT/employee #1 stated there was no registered nurse/director of nurses available to destroy the medications. She further stated she had not seen, nor did she know what the discontinued medications policy documented.	R 622		
R 623 SS=F	310:680-13-1 (1)(V) MEDICATIONS - DISPOSAL Correct medication and pharmacy techniques and principles shall be used when medications are administered or monitored. The home shall comply with the following: (1) Storage and Maintenance. (V) The home shall have a written policy for safe disposal of discontinued medications and it shall be an approved method by the State Department of Health. Documentation shall be retained in the individual resident's record. Over-the-counter medications shall be destroyed in the presence of two (2) residential care home staff persons. Documentation shall include the	R 623		

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R 623	Continued From page 16 name of the medication, the amount destroyed, the method of destruction, and shall be retained in the individual resident's record. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to develop a written policy and procedure for safe disposal of discontinued medications. This failed practice had the widespread potential for more than minimal harm for all 10 residents who received employee administered physician ordered medications. Findings: On 06/26/19 at 3:05 p.m., a discontinued medication destruction manual was reviewed. There was no policy for safe disposal of discontinued medications in that manual. Long term care aide/medication administration technician stated she had not seen a policy for discontinued medication disposal since she had worked in the home since July 2018. No medication disposal policy was found in any submitted manual throughout the survey.	R 623		
R 813 SS=E	310:680-19-2 (a)(5) STATEMENT PROVISIONS (a) A statement of rights and responsibilities shall include but not be limited to the following: (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident shall be fully informed by his attending physician of his medical condition and proposed treatment in terms and language that the resident can understand, unless medically	R 813		

Oklahoma State Department of Health

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R 813	Continued From page 17 contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to ensure physician ordered medication was available and/or administered to 3 (#2, 3, and #6) of 6 sampled residents. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #2 Resident #2 moved into the home on 09/04/17 with diagnoses that included anxiety, depression, and insomnia. A June 2018 medication administration record (MAR) for resident #2 documented, "...Melatonin (used to treat insomnia) 20 mg (milligrams) (2) tabs (tablets) (10mg) po (by mouth) q (every) HS (hour of sleep) 4/30/18 (original order date)..." On 06/27/19 at 11:45 a.m., long term care aide/medication administration technician (LTCA/MAT) was asked for the most current physician's order for resident #2's Melatonin. She submitted a hospital discharge summary, dated 07/14/18, that documented, "...melatonin 5 mg capsule Take 1 capsule everyday by oral route in the evening..." When asked how much Melatonin	R 813		

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R 813	Continued From page 18 had been administered to resident #2, she went to the medication cart and retrieved the over-the-counter bottle of Melatonin 10 mg and stated, "20 milligrams." She then stated she had known resident #2 had received the Melatonin 20 mg since she was employees in the home in July 2018. RESIDENT #3 Resident #3 moved into the home on 06/21/19 with diagnoses that included hypertension, hyperlipidemia, and atherosclerosis. A medication list for resident #3 sent to the home on 06/18/19 documented, "...Metoprolol Succinate (used to treat hypertension) ER (extended release) 25MG Take 1 Tablet By Mouth Twice Daily... Atorvastatin Calcium (used to treat high cholesterol) 40MG Take 1 Tablet By Mouth Daily... Clopidogrel Bisulfate (used to treat atherosclerosis) 75MG 1 Tablet Daily..." A June 2018 MAR for resident #3 documented, "...Atorvastatin Calcium 40mg 1 tab po QD (every day) Dx: (diagnosis) hyperlipidemia 2-5-19 (original order date)..." The daily blocks from 06/22/19 through 06/25/19 contained circled initial to indicate resident #3 had not received the medication. A written explanation on the back of the MAR documented, "... 6-22...Circled med (medication) on order...6-23...Circled med on order..." The June MAR for resident #3 also documented, "...Clopidogrel Bisulfate 75mg 1 tab PO QD 5-12-16 (original order date) Dx: Atherosclerosis..." The daily blocks from	R 813		

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R 813	Continued From page 19 06/22/19 through 06/27/19 contained circled initial to indicate resident #3 had not received the medication. Handwritten explanation on the back off the MAR documented the medication was "on order." The June MAR or resident #3 also documented, "...Metoprolol Succinate ER 25mg 1 tab PO BID (twice a day) Dx: HTN (hypertension) 2-5-19 (original order date)..." The daily blocks at 8:00 p.m. on 06/21/19, 06/24/19, and 06/25/19, had been circled to indicate the medication had not been administered to resident #3. Handwritten explanation on the back of the MAR documented, "...6-21 2000 (8:00 p.m.)...Metoprolol held BP (blood pressure) 122/60 P (pulse) 73... 6-24 2000...Metoprolol held BP 107/54-52... 6-25 2000...Metoprolol held BP 114/54 p 48..." On 06/26/19 at 2:25 p.m., LTCA/MAT/employee #1 was asked for the reason resident #3 had not received his Atorvastatin and Clopidogrel medications as his physician had ordered. She stated his family had not picked it up at the pharmacy and brought it to the home. When asked about the circled and held Metoprolol medication, LTCA/MAT/employee #1 stated, "The MATs thought anything (blood pressures) under 120/60, we had to hold (B/P medications)." She stated resident #3's physician had not been notified the blood pressure medication had been held and not given as ordered. LTCA/MAT/employee #1 also stated the physician had not written blood pressure perimeters on the medication orders for when the medication was to be held. RESIDENT #6	R 813		

Oklahoma State Department of Health

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R 813	Continued From page 20 Resident #6 moved into the home on 02/02/19 with diagnoses that included acute pain and depression disorder. A June 2018 MAR for resident #6 documented, "...IBU (Ibuprofen) 800mg 1 tab TID (three times a day) DX: Pain..." The daily blocks from 8:00 p.m. on 06/24/19 through 8:00 p.m. on 06/25/19 (total of 4 doses) were circled to indicate the medication had not been administered to resident #6. Handwritten documentation on the back of the MAR documented the pain medication was "on order." On 06/25/19 at 1:37 p.m., MAT/employee #2 stated resident #6's Ibuprofen 800 mg was "on order." At 1:42 p.m., resident #6 asked MAT/employee #2 about her missing pain medication, and was told the medication had been ordered. Resident #6 was asked how she was doing without the pain medication available. She stated, "Fair. I'll make it. I hurt." On 06/27/19 at 1:48 p.m., LTCA/MAT/employee #1 was asked if resident #6's physician had been notified the resident had not been administered her prescribed pain medication. She stated she had not notified the physician.	R 813			

STATE WORKLOAD REPORT

Provider/Supplier Number RC7303	Provider/Supplier Name WAGONER HEALTH & REHAB RES CARE
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Type of Survey (select all that apply)

☒ 2 ☐ ☐ ☐ ☐

- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | 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)
1.  25837	06/25/2019	06/27/2019	0.50	0.00	20.75	0.25	3.25	8.25
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



Oklahoma State Department of Health
Creating a State of Health

August 5, 2019

License Number: RC7303

Survey Event ID: N1J211

Ms. Elizabeth Chapman, Administrator
Wagoner Care Center Res. Care
205 North Lincoln
Wagoner, OK 74467

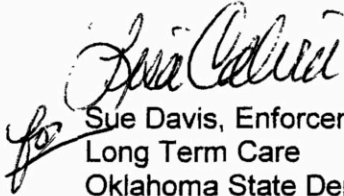
Dear Ms. Chapman:

On **June 27, 2019**, agents from our office completed an investigation at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **R0510 and R0602-** The home did not include Plan of Correction Dates for R 510 or R 602.

An amended plan of correction is due within 10 days of receipt of this notice.

Sincerely,



Sue Davis, Enforcement Coordinator
Long Term Care
Oklahoma State Department of Health

SD/lde
Enclosure

Board of Health

Tom Bates, JD
Interim Commissioner of Health

Timothy E Starkey, MBA (*President*)
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Jenny Alexopoulos, DO
Terry R Gerard II, DO
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N 000	Initial Comments A re-licensure survey was conducted on 06/25/19 through 06/27/19. Current census was 10. The following deficiencies were cited.	N 000	N 1105 Corrective Action: On 6/27/2019, upon notification of deficient practice, Admin/designee reviewed facility records for required in-service training. On 7/10 and 7/25 Inservice was provide to meet the requirements of compliance.	
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 two hours of in-service training supervised by a registered nurse was provided monthly for 2 (#1 and #4) of 2 long term care aides (LTCA) who provided direct resident care. This failed practice had the potential for more than minimal harm at a pattern for all 12 residents. Findings: On 06/26/19 at 4:00 p.m., the employees' in-service training records were reviewed and	N1105	Identification of others with the potential of being affected: A review of Facility records showed 10 residents had the potential to be affected by the deficient practice. To ensure deficient practice does not recur: On 7/1/2019, Regional Manager in serviced staff on In-service requirements. Monitoring: Beginning 7/10/2019, Admin/Designee will monitor facility records bi- Monthly Xs 2 months and monthly until substantial compliance is maintained. Any Negative findings will be corrected and reported immediately. QA: Admin/Designee will present any negative findings to QA minutes and be reviewed by the QA committee for further recommendations.	8/17/2019

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Elizabeth Chapman

TITLE

Administrator

(X6) DATE

08/02/2019

Oklahoma State Department of Health

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N1105	Continued From page 1 there was no start and stop times documented to determine the lengths of each in-service, nor was there a documented name of the person who provided the in-services. At 4:09 p.m. LTCA/MAT (medication administration employee)/employee #1 stated she had provided each of the in-services. At 6:00 p.m., the administrator stated a registered nurse had not supervised any of the in-services provided to the LTCA employees.	N1105	N1442 Corrective Action: On 6/27/2019, upon notification of deficient practice, Admin/designee reviewed employee records for required skills check off sheets. Any negative findings were corrected. Identification of others with the potential of being affected: A review of Facility records showed 10 residents had the potential to be affected by the deficient practice.	
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure certified medication aide (CMA) skills were validated prior to administering medication for 1 (#4) of 1 CMA who had been hired within the past year. This had the widespread potential for more than minimal harm for all 10 residents. Findings: On 06/26/19 at 3:43 p.m., the file for CMA #4 did not contain a medication skills checklist documented by a licensed nurse in her file.	N1442	To ensure deficient practice does not recur: On 7/1/2019, Regional Manager in served staff on skills review requirements upon hire and annually thereafter. Monitoring: Beginning 7/10/2019, Admin/Designee will monitor employee records Monthly Xs 3 months and quarterly until substantial compliance is maintained. Any Negative findings will be corrected and reported immediately. QA: Admin/Designee will present any negative findings to QA minutes and be reviewed by the QA committee for further recommendations.	8/15/2019

Oklahoma State Department of Health

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N1442	Continued From page 2 At 11:50 a.m., long term care aide/medication administration technician (LTCA/MAT) stated she was the only person who had checked off LTCA/CMA #4's skills after she was hired to work double shifts on the weekends.	N1442	R204 R 204 Corrective Action: On 6/27/2019, upon notification of deficient practice, Admin/designee reviewed facility records for update to physician service agreement. Agreement updated 6/28/2019. Any negative findings were corrected.	
R 000	INITIAL COMMENTS A re-licensure survey was conducted on 06/25/19 through 06/27/19. Current census was 10. The following deficiencies were cited.	R 000	Identification of others with the potential of being affected: A review of Facility records showed 10 residents had the potential to be affected by the deficient practice. To ensure deficient practice does not recur: On 7/1/2019, Regional Manager in serviced staff on physician service requirements and renewal of agreements annually.	
R 204 SS=F	310:680-3-3 (d) & (e)(1) INSPECTIONS, PHYSICIAN AND EMS SERVICES (d) An application for an initial license to operate a residential care home shall include documentation that the State Fire Marshal or the State Fire Marshal's representative has inspected and approved the home. Each application for renewal of a license for a residential care home with more than six beds shall include documentation of annual inspection and approval by the State Fire Marshal or the State Fire Marshal's representative. (e) The following items must be renewed annually: (1) An agreement with a physician to provide emergency medical services and consultation.	R 204	Monitoring: Beginning 7/10/2019, Admin/Designee will monitor facility records Monthly Xs 3 months and quarterly until substantial compliance is maintained. Any Negative findings will be corrected and reported immediately. QA: Admin/Designee will present any negative findings to QA minutes and be reviewed by the QA committee for further recommendation.	6/28/2019

Oklahoma State Department of Health

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R 204	Continued From page 3 This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure an agreement with a physician to provide medical consultation was renewed annually. This failed practice had the widespread potential for more than minimal harm for all 10 residents. Findings: On 06/25/19 at 3:30 p.m., the most current physician's agreement found was dated 05/19/18. On 06/27/18 at 3:42 p.m., the administrator was asked about the missing annual physician's agreement. She stated she had not obtained a current agreement.	R 204	R205 Corrective Action: On 6/27/2019, upon notification of deficient practice, Admin/designee reviewed facility records for update to pharmacist service agreement. Agreement updated 7/20/2019 Any negative findings were corrected. Identification of others with the potential of being affected: A review of Facility records showed 10 residents had the potential to be affected by the deficient practice. To ensure deficient practice does not recur: On 7/1/2019, Regional Manager in serviced staff on pharmacist service requirements and renewal of agreements annually. Monitoring: Beginning 7/10/2019, Admin/Designee will monitor facility records Monthly Xs 3 months and quarterly until substantial compliance is maintained. Any Negative findings will be corrected and reported immediately. QA: Admin/Designee will present any negative findings to QA minutes and be reviewed by the QA committee for further recommendations.		7/20/2019
R 205 SS=F	310:680-3-3 (e)(2) NURSE, DIETITIAN, AND REGISTERED PHARMACIST (e) The following items must be renewed annually: (2) Agreements with registered nurse, registered dietitian, and registered pharmacist, as required based on the needs of the residents.	R 205			

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R 205	Continued From page 4 This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure an agreement with a pharmacist was renewed annually. This failed practice had the widespread potential for more than minimal harm for all 10 residents who received employee administered physician ordered medications. Findings: On 06/26/19 at 3:30 p.m., a review of agreements was conducted and the most current pharmacist's agreement was dated 01/01/17. At 4:56 p.m., the administrator #1 stated she had not obtained an agreement with the new pharmacy the home had begun to use.	R 205	R 207 Corrective Action: On 6/27/2019, upon notification of deficient practice, Admin/designee reviewed facility records for update to facility inspection report. Any negative findings were corrected. Identification of others with the potential of being affected: A review of Facility records showed 10 residents had the potential to be affected by the deficient practice. To ensure deficient practice does not recur: On 7/1/2019, Regional Manager in served staff on annual inspections and maintaining records. Monitoring: Beginning 7/10/2019, Admin/Designee will monitor facility records Monthly Xs 3 months and quarterly until substantial compliance is maintained. Any Negative findings will be corrected and reported immediately. QA: Admin/Designee will present any negative findings to QA minutes and be reviewed by the QA committee for further recommendations.	08/17/2019	
R 207 SS=F	310:680-3-3 (e)(4) ELECTRICIAN, MUNICIPAL INSPECTOR'S REPORT (e) The following items must be renewed annually: (4) Licensed electrician or municipal inspector's report. This Rule is not met as evidenced by: Based on interview and record review, it was	R 207			

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R 221	Continued From page 6	R 221	R221	
R 221 SS=F	310:680-3-6 (b)(5) RETAINING A LIST OF PERSONNEL (b) Every residential care home shall retain the following for public inspection: (5) A list of personnel who are licensed, certified, or registered and employed or retained by the residential care home, including area in which individual is credentialed. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to retain a list of personnel who were licensed, certified, registered, and employed or retained by the home. This failed practice had the widespread potential for minimal harm for all 10 residents. Finding: On 06/25/19 at 3:15 p.m., information boards by the medication room door and on a wall by the dining by the were observed. No list of current personnel was found. long term care aide/medication administration technician (LTCA/MAT) was asked if a list of employed or retained personnel was available for inspection. She stated previously posted list had been taken down.	R 221	Corrective Action: On 6/27/2019, upon notification of deficient practice, Admin/designee reviewed facility records for update and posting of current facility personnel. Any negative findings were corrected. Identification of others with the potential of being affected: A review of Facility records showed 10 residents had the potential to be affected by the deficient practice. To ensure deficient practice does not recur: On 7/1/2019, Regional Manager in serviced staff on posting and maintaining list of employees. Monitoring: Beginning 7/10/2019, Admin/Designee will monitor facility records Monthly Xs 3 months and quarterly until substantial compliance is maintained. Any Negative findings will be corrected and reported immediately. QA: Admin/Designee will present any negative findings to QA minutes and be reviewed by the QA committee for further recommendations.	8/15/2019
R 225 SS=F	310:680-3-6 (e) EVACUATION PLAN AND FIRE DRILLS (e) An evacuation plan shall be developed and permanently displayed in the hallways and sitting room. Fire drills shall be conducted at least	R 225		

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R 225	Continued From page 7 quarterly. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure fire drills were conducted at least quarterly. This failed practice had the widespread potential for more than minimal harm for all 10 residents. Findings: On 06/25/19 at 3:11 p.m., long term care aide/medication administration technician/employee #1 was asked for the most recent fire drills. She stated, "We don't have them." She stated she did not know why, but she had not a had fire drill in the home. At 3:30 p.m., maintenance/employee #5 was asked for the past years fire drills. He submitted a manual, but there were no fire drills documented for the residential care home. He stated he had not conducted the required quarterly fire drills.	R 225	Corrective action: On 6/27/2019 , upon notification of deficient practice, maintenance/ designee began conducting fire drills facility. any negative findings were corrected. Identification of others with potential of being affected: A review of resident census, facility identified 10 residents residing in the facility have the potential to be affected by this deficient practice. To ensure deficient practice does not recur: On 7/1/2019 staff in-serviced on policy and procedure of fire drills. Monitoring: Maintenance/designee will monitor for compliance monthly to ensure fire drills are being completed per shift. Any negative findings will be reported to the monthly QA minutes.	8/10/2019
R 317 SS=F	310:680-5-3 (d) MAXIMUM TEMPERATURE 85 F (d) Maximum temperature in all areas occupied by residents shall not exceed 85 degrees Fahrenheit, unless authorized or recommended by a physician. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure all areas of the home occupied by residents did not exceed 85 degrees Fahrenheit (F). This failed practice had the potential for more than minimal harm for	R 317	QA: Negative findings and corrections will be reported and documented in quarterly QA minutes for further recommendations.	

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NAME OF PROVIDER OR SUPPLIER WAGONER HEALTH & REHAB RES CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 205 NORTH LINCOLN WAGONER, OK 74467
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R 317	Continued From page 8 all 10. Findings: On 06/25/19 at 11:21 a.m., the ambient air temperature in the main entrance living room/nurses' desk area registered at 85.2 degrees F. Long term care aide/medication administration technician (LTCA/MAT)/employee #1 stated the air conditioner had not worked and the home had been hot for about one and one-half months. At 11:37 a.m., resident #1 stood at the front nurses' desk area while she retrieved snack crackers from a basket on the desk. She said she was warm there. At 11:41 a.m., maintenance/employee #5 also stated the air conditioner had not worked properly for about one and one-half months. At 2:27 p.m., the ambient air temperature registered at 87.5 degrees F near the main entrance nurses' desk area. Resident #7 walked in halls by front nurses' desk. At 4:35 p.m., the ambient air temperature registered at 88.2 degrees F near the main entrance nurses' desk area. Both LTCA/MAT/employee #1 and MAT/employee #2 stated it was too hot in that area. At 3:05 p.m., the ambient air temperature in the nurses' desk area registered at 87.4 degrees F.	R 317	R 317 Corrective action: On 6/27/2019, upon notification of deficient practice, maintenance/designee repaired air units in facility. any negative findings were corrected. Identification of others with potential of being affected: A review of resident census, facility identified 10 residents residing in the facility have the potential to be affected by this deficient practice. To ensure deficient practice does not recur: On 7/1/2019 staff in-serviced on policy and procedure of maintaining ambient temp. Monitoring: Maintenance/designee will monitor for compliance weekly to ensure ambient temps are being maintained. Any negative findings will be reported to the monthly QA minutes. QA: Negative findings and corrections will be reported and documented in quarterly QA minutes for further recommendations.	7/10/19
R 349 SS=F	310:680-7-1 CONTROL OF PREMISES The administrator shall have access to and authority over the entire premises. The person in charge shall be specifically designated in writing	R 349		

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R 349	Continued From page 9 by the administrator and shall have authority to act in his/her absence and have access to the home's records if the owner or operator is not immediately available. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the administrator failed to ensure the person in charge was specifically designated in writing. This failed practice had the widespread potential for more than minimal harm for all 10 residents. Findings: On 06/25/19 at 4:24 p.m., long term care aide/medication administration technician was asked if the person in charge had been designated in writing, to act in the administrator's absence. She stated, "I've never had anything in writing or posted." There was no person in charge document posted on either of the two (2) information boards, nor found in any of the submitted manuals.	R 349	R 349 Corrective Action: On 6/27/2019, upon notification of deficient practice, Admin/designee reviewed facility records for update to control of premises written authorization. Any negative findings were corrected. Identification of others with the potential of being affected: A review of Facility records showed 10 residents had the potential to be affected by the deficient practice. To ensure deficient practice does not recur: On 7/1/2019, Regional Manager in serviced staff on control of premises in written notification. Monitoring: Beginning 7/10/2019, Admin/Designee will monitor facility records Monthly Xs 3 months and quarterly until substantial compliance is maintained. Any Negative findings will be corrected and reported immediately.		
R 507 SS=F	310:680-11-1 (2)(B) STAFF QUALIFICATIONS - MEDICATION (2) Staff Qualifications. (B) All personnel who have the responsibility for administering or monitoring medication to residents shall obtain a certificate of training in medication administration from an institution of higher learning whose program has been reviewed by the Department. (Currently licensed physicians, registered nurses and licensed practical nurses shall be deemed to meet the medication administration training requirement.)	R 507	QA: Admin/Designee will present any negative findings to QA minutes and be reviewed by the QA committee for f urther recommendations.		7/01/19

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R 507	Continued From page 10 This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to ensure 1 (#3) of 5 employees who had the responsibility for administering medication was qualified and trained from an approved institution of higher learning. This failed practice had the widespread potential for more than minimal harm for all 10 residents who received employee administered physician ordered medications. Findings: On 06/26/19 at 3:34 p.m., the employees' files were review and revealed Department of Developmental Services medication administration technician (DDS MAT)/employee #3 was hired on 2/20/19. The sampled residents' June 2018 medication administration records documented DDS MAT/employee #3 administered their medications on the following dates: 06/01/19; 06/02/19; 06/08/19; 06/09/19; 06/14/19; 06/15/19;	R 507	Corrective Action: On 6/27/2019, upon notification of deficient practice, Admin/designee reviewed employee records for up to date and required qualifications. Any negative findings were corrected. Identification of others with the potential of being affected: A review of Facility records showed 10 residents had the potential to be affected by the deficient practice. To ensure deficient practice does not recur: On 7/1/2019, staff in serviced on required qualifications of personnel. Monitoring: Beginning 7/10/2019, Admin/Designee will monitor Employee records Monthly Xs 3 months and quarterly until substantial compliance is maintained. Any Negative findings will be corrected and reported immediately. QA: Admin/Designee will present any negative findings to QA minutes and be reviewed by the QA committee for further recommendations.	08/17/2019

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R 507	Continued From page 11 06/16/19; 06/20/19; 06/22/19; and 06/23/19. At 4:18 p.m., DDS MAT/employee #3's file had a of Department of Human Services certificate that she was given for DDS Medication Administration Technician Training on 06/08/18. Long term care aide/medication administration technician (LTCA/MAT) was asked about DDS MAT/employee #3's training. She stated she did not know about the training due to DDS MAT/employee #3 had been hired in the nursing home next door. On 06/27/19 at 2:59 p.m., DDS MAT/employee #3 was observed on duty as she passed medications.	R 507			
R 510 SS=F	310:680-11-1 (3)(A) STAFF TRAINING - FIRST AID/CPR (3) In order to ensure all homes maintain a level of competency necessary to meet the needs of each individual served in the home, personnel must complete the following training requirements. (A) All employees shall be currently certified in first-aid and cardiopulmonary resuscitation (Red Cross training or equivalent). Proof of certification and training shall be kept on file in the home. First-Aid and CPR certificates shall be renewed annually, or as required to be kept current.	R 510			

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R 602	Continued From page 13 (1) Storage and Maintenance. (A) Medications shall be stored in an area that is locked, is well lighted, and room temperature not to exceed 86 degree Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure the residents' medications were stored in a room temperature that did not exceed 86 degrees Fahrenheit (F). This failed practice had the widespread potential of more than minimal harm for all 10 residents who received employee administered physician ordered medications. Findings: On 06/25/19 at 4:35 p.m., the ambient air temperature registered at 88.2 degrees F near the main entrance nurses' desk area. Both LTCA/MAT/employee #1 and MAT/employee #2 stated it was too hot in that area. The medication cart was still parked in its normal space, an enclosure in the wall by the medication room door. On 06/26/19 at 9:07 a.m., the medication room door was opened and it was very warm in there. The ambient air temperature in there registered at 88 degrees F on a thermometer on a wall. At 9:27 a.m., the administrator stated the home's pharmacist verbalized to her the residents' medications in the medication room would need	R 602	Corrective action: On 6/27/2019 , upon notification of deficient practice, maintenance/ designee repaired air units in med room on 6/27/2019. any negative findings were corrected. Identification of others with potential of being affected: A review of resident census, facility identified 10 residents residing in the facility have the potential to be affected by this deficient practice. To ensure deficient practice does not recur: On 7/1/2019 staff in-serviced on policy and procedure of maintaining safe temp. for medication storage. Monitoring: Maintenance/designee will monitor for compliance weekly Xs 3 weeks to ensure safe temps are being maintained. Any negative findings will be reported to the monthly QA minutes. QA: Negative findings and corrections will be reported and documented in quarterly QA minutes for further recommendations.	

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R 602	Continued From page 14 to be replaced. At 3:05 p.m., the ambient air temperature in the medication room registered at 90 degrees F. The ambient air temperature in the nurses' desk area near the medication cart registered at 87.4 degrees F. On 06/27/19 at 8:57 a.m., the ambient air temperature in the medication room registered at 88 degrees F on the wall thermometer. Many of the medications in that room had labels that documented the medications should be stored at 68 to 77 degrees F.	R 602	Corrective action: 6/27/2019, upon notification of deficient practice, the Admin/designee updated medication storage/destruct policy reviewed Medication storage areas, and destructed any discontinued meds in accordance with policy. Any negative findings were corrected and addressed immediately. Identification of others with potential of being affected: A review of resident census, facility identified 10 residents have the potential to be affected by this deficient practice. To ensure deficient practice does not recur: On 7/10/2019, admin/designee in serviced nursing staff on medication storage and destruction. Monthly destruct to begin August 2019 and monitored by admin for compliance.		8/1/2019
R 622 SS=F	310:680-13-1 (1)(U) MEDICATIONS - DISCONTINUED Correct medication and pharmacy techniques and principles shall be used when medications are administered or monitored. The home shall comply with the following: (1) Storage and Maintenance. (U) Discontinued medications may be kept up to three (3) months and must be separated from the current medications within the locked medication area. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to ensure discontinued medications were kept only up to three (3) months. This failed practice had	R 622	Monitoring: Admin/designee will monitor monthly destruct log and medication storage areas for compliance monthly until substantial compliance is maintained. Any negative findings will be corrected immediately and reported to the monthly QA minutes. QA: Negative findings and corrections will be reported and documented in quarterly QA minutes for further recommendations.		