

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

PRINTED: 11/15/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/27/2021
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE CT SKILLED CARE CTR AT MAGNOLIA TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE ONE CROWN CIRCLE HUNTSVILLE, AL 35802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 658 SS=D	<p>An Abbreviated Survey was conducted on October 27, 2021 for the investigation of complaint/report number AL00041460. F658 and F842 were cited at past non-compliance as a result of the investigation of this complaint. Willowbrooke Court Skilled Care Center at Magnolia Trace is in compliance with applicable requirements of 42 CFR Part 483, Health Standard Requirements for Long Term Care Facilities.</p> <p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews, record reviews, a review of Potter and Perry, "Fundamentals of Nursing, " NINTH EDITION, and a review of the facility's policy titled, "MEDICATION ADMINISTRATION & MANAGEMENT," the facility failed to ensure that Employee Identifier (EI) #4, Registered Nurse (RN), followed the physician's orders in accordance with professional standards of practice.</p> <p>EI #4 administered Hydrocodone-Acetaminophen tablet instead of liquid Hydrocodone-Acetaminophen as ordered to Resident Identifier (RI) #5.</p> <p>EI #4 administered Hydrocodone-Acetaminophen to RI #8 at 08:00PM when it should have been</p>	F 658	Past noncompliance: no plan of correction required.	11/10/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
11/10/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	<p>Continued From page 1 administered at 08:00AM.</p> <p>This deficient practice affected RI #5 and RI #8, two out of 19 residents sampled for controlled medications.</p> <p>Findings include:</p> <p>Review of Potter and Perry's "Fundamentals of Nursing", NINTH EDITION, page 31, revealed the following: "...Chapter 23 Legal Implication in Nursing Practice...Health Care Provider's Orders. The health care provider (physician...) is responsible for directing medical treatment. Nurses follow health care provider's orders unless they believe the orders are in error or harm patients..."</p> <p>Review of the facility's policy, titled, "MEDICATION ADMINISTRATION & MANAGEMENT," issued 03/2012 and last revised 10/2019, revealed the following: " ...PROCEDURE: ... 4. Prior to Medication Administration: All authorized community staff should adhere to the following guidelines: a. Verify the correct drug, correct dose, correct route, correct rate, correct time and the correct resident prior to each medication administration. ... "</p> <p>1.) RI #5 was admitted to the facility on 11/17/2016 and readmitted 05/29/2021.</p> <p>RI #5's physician orders, "Order Summary Report" for June 2021 indicated Hydrocodone-Acetaminophen Tablet 5-325mg was ordered 06/08/2021 to be given one tablet by mouth at bedtime for pain. This order was</p>	F 658			

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F 658	<p>Continued From page 2</p> <p>discontinued on 06/09/2021. The physician ordered Hydrocodone-Acetaminophen Solution 7.5-325mg/ml on 06/09/2021 to be given 10ml by mouth at bedtime for pain.</p> <p>A review of RI #5's Controlled Drug Record indicated EI #4, RN, administered one Hydrocodone-Acetaminophen Tablet 5-325mg on 07/01/2021 at 09:00PM instead of the liquid solution.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, Director of Nursing (DON), reported EI #4 administered the last Hydrocodone 5-325mg pill to RI #5 on 07/01/2021 at 09:00PM. EI #2 stated it was an error because the wrong form of the medication was given. EI #2 stated the narcotic count was correct so it appeared EI #4 gave the tablet to the resident. EI #2 stated EI #4 should have read the order and followed the five rights from the facility policy.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 signed for the tablet on the narcotic log on 07/01/2021, which was the incorrect medication form. EI #1 stated RI #5 did not like taking pills. EI #1 stated EI #4 should have provided the correct dose and correct form as ordered by the physician. EI #1 stated EI #4 did not follow medication administration policy. EI #1 stated EI #4 did not meet professional standards of practice.</p> <p>2.) RI #8 was admitted to the facility on 12/30/2011 and readmitted 10/22/2012.</p> <p>RI #8's Medication Review Report for July 2021 indicated Norco Tablet 5-325mg (Hydrocodone-Acetaminophen) was ordered</p>	F 658			

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F 658	<p>Continued From page 3</p> <p>09/09/2018 one tablet to be given by mouth in the morning (08:00AM) for pain.</p> <p>A review of RI #8's Controlled Drug Record indicated EI #4 administered one tablet of Hydrocodone-Acetaminophen on 07/01/2021 at 08:00PM.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported RI #8's Norco 5-325mg was scheduled in the morning. EI #2 stated EI #4 worked 3-11PM. EI #2 stated dayshift gave the resident the medication. EI #4 signed out the medication again on 07/01/2021 at 08:00PM. EI #2 stated if EI #4 gave the medication to the resident, she gave it without an order.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 signed for the Norco on the narcotic log on 07/01/2021 but not on the Medication Administration Record (MAR). EI #1 stated the Norco was scheduled for 08:00AM but EI #4 signed for it at 08:00PM. EI #1 stated the medication was given at the wrong time. EI #1 stated the resident should have received the correct medication at the appropriate time and it should be documented on the narcotic log and the MAR. EI #1 stated RI #8 received a dose at 08:00AM and then EI #4 administered the medication again at 08:00PM. EI #1 stated EI #4 did not follow the medication administration policy. EI #1 stated EI #4 did not meet professional standards of practice.</p> <p>*****</p> <p>The facility implemented the following corrective actions:</p> <p>*An investigation was conducted and EI #4 was</p>	F 658			

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F 658	Continued From page 4 suspended during the investigation. EI #4 was terminated 07/16/2021. *A house-wide audit completed 07/14/2021. *ADON notified the Medical Director on 07/13/2021. *Administrator notified the Pharmacy Consultant on 07/13/2021. *A Performance Improvement Plan was created and implemented. *All licensed nurses were re-educated on 07/13/2021 regarding Controlled Medication, Medication Storage and Medication Documentation and Administration. *EI #5 received one-on-one coaching regarding Medication Administration policy. Monthly medication pass observations for EI #5 began 07/2021 and will continue for six months. *Random Medication Pass Competencies on nurses were completed two times a week for four weeks and then weekly for four weeks. Completed 09/10/2021. *Narcotic Reconciliation Audits three times a week for four weeks, two times a week for four weeks and ongoing weekly. Two times a week completed 09/10/2021. Corrective actions began 07/13/2021 and were completed 09/10/2021. Therefore, past non-compliance was cited.	F 658			
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		11/10/21	

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F 842	<p>Continued From page 5</p> <p>agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained</p>	F 842			

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F 842	<p>Continued From page 6</p> <p>for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews, resident record reviews, facility documentation of a narcotic audit and a review of the facility's policy titled, "Medication, Controlled Substances," the facility failed to ensure licensed staff documented correctly on administration of narcotics on the narcotic log and the Medication Administration Record (MAR).</p> <p>A facility narcotic audit was done of all narcotics on 07/14/2021 revealing: 1.) Employee Identifier (EI) #4, Registered Nurse (RN), failed to document narcotic medication administration on the MAR for Resident Identifier (RI) #3, RI #6, RI #8, RI #9, RI #10 and RI #11; 2.) to document on the narcotic log that narcotics were pulled for RI #2, RI #3, RI #4, RI #5, RI #7, RI #8 and RI #10; 3.) EI #4 document on the MAR only medication for RI #1 that was pulled and administered; and</p>	F 842	Past noncompliance: no plan of correction required.		

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F 842	<p>Continued From page 7</p> <p>4.) EI #5, Licensed Practical Nurse (LPN), document medication administration on the MAR for RI #12, RI #13, RI #14 and RI #15.</p> <p>This affected 15 out of 19 residents who received controlled medications from 07/01/2021 through 07/15/2021.</p> <p>Findings include:</p> <p>Review of the facility policy titled, "Medication, Controlled Substances," issued 04/2006 and last revised 10/2018, revealed the following: " ... Policy: To strive to ensure that strict management of controlled substances is maintained as evidenced by special handling, storage, disposal and recordkeeping. Purpose: *To ensure the proper storage and security of controlled drugs. *To minimize the potential for abuse of controlled drugs. *To comply with state and federal regulations. Procedure: ... 5. When a resident receives a narcotic, the licensed nurse signs off each dose of the controlled medication given by documenting the following on the narcotic sheet and the electronic medication administration record (MAR): a. Date medication given b. Time medication given c. Medication dose given d. Amount of medication remaining e. Signature of nurse administering medication ..."</p> <p>1.) RI #3 was admitted to the facility on 06/08/2017.</p>	F 842			

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F 842	Continued From page 8 RI #3's Medication Review Report for July 2021 indicated Hydrocodone-Acetaminophen Tablet 5-325mg was ordered 05/28/2021 two tablets by mouth every four hours as needed for pain. A review of RI #3's Controlled Drug Record indicated EI #4, RN, administered one tablet Hydrocodone-Acetaminophen 5-325mg on 07/10/2021 at 10:15PM. A review of RI #3's Medication Administration Record for the month of July 2021 indicated no documentation of administration of Hydrocodone-Acetaminophen on 07/10/2021 at 10:15PM. In an interview on 10/26/2021 at 10:40AM, EI#3, Assistant Director of Nursing (ADON), stated EI #4 signed the narcotic log on 07/01/2021 but did not chart on the MAR. EI #3 stated EI #4 did not follow the facility's Controlled Medication Policy. In an interview on 10/27/2021 at 09:29AM, EI #2, Director of Nursing (DON), reported EI #4 signed the narcotic log that she pulled the Norco on 07/10/2021 but she did not chart the administration on the MAR. EI #2 stated EI #4 documented in one area but not the other. EI #2 stated EI #4 should have documented properly and ensured she gave the medication, then there would be no question whether the patient got the medication or not. EI #2 stated the record would not be considered complete and accurate if it was not documented on the MAR. The facility's policy was not followed. EI #2 stated if a record was not complete and accurate, it leaves a question as whether the resident received or did not receive the medication as ordered.	F 842			

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F 842	Continued From page 9 An interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 signed on the narcotic log that she pulled the Norco on 07/10/2021 but she did not document on the MAR. EI #1 stated this was inaccurate documentation. EI #1 stated that when the medication was given, EI #4 should have documented on the narcotic log and the MAR. 2.) RI #6 was admitted to the facility on 04/20/2021 and readmitted on 06/09/2021. RI #6's Medication Review Report for July 2021 indicated Norco Tablet 5-325mg (Hydrocodone-Acetaminophen) was ordered 06/10/2021 one tablet by mouth every eight hours as needed for pain. A review of RI #6's Controlled Drug Record indicated EI #4, RN, administered one tablet of Hydrocodone-Acetaminophen 5-325mg on 07/11/2021 at 04:30PM. A review of RI #6's Medication Administration Record for the month of July 2021 indicated no documentation of administration of Norco (Hydrocodone-Acetaminophen) on 07/11/2021 at 04:30PM. In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #4 documented on the narcotic log that Norco was given on 07/11/2021 but she did not document on the MAR. EI #2 stated this was a documentation issue. EI #2 stated the record would not be considered complete and accurate if the nurse did not document on the MAR. EI #2 stated facility policy for documentation was not followed. EI #2 stated if a	F 842			

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F 842	<p>Continued From page 10</p> <p>record was not complete and accurate, it leaves a question whether the resident received or did not receive the medication as ordered by the physician.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 documented on the narcotic log that Norco was given on 07/11/2021 but she did not document on the MAR.</p> <p>3.) RI #8 was admitted to the facility on 12/30/2011 and readmitted on 10/22/2012.</p> <p>RI #8's Medication Review Report for July 2021 indicated Norco Tablet 5-325mg (Hydrocodone-Acetaminophen) was ordered 09/09/2018 one tablet by mouth in the morning for pain.</p> <p>RI #8's Controlled Drug Record indicated EI #4, RN, administered one tablet of Hydrocodone-Acetaminophen 5-325mg on 07/01/2021 at 08:00PM.</p> <p>A review of RI #8's Medication Administration Record for the month of July 2021 indicated Norco (Hydrocodone-Acetaminophen) was not documented being administered on 07/01/2021 by EI #4.</p> <p>In an interview on 10/26/2021 at 10:40AM, EI #3, ADON, reported EI #4 signed out the Norco on the narcotic log but she did not sign the MAR. EI #3 stated EI #4 was not following the medication administration policy because she signed out the narcotic on the narcotic log but not on the MAR.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, stated the medication was ordered to be</p>	F 842			

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F 842	<p>Continued From page 11</p> <p>given in the morning. EI #4 worked 3PM-11PM. It was not documented on the MAR on 07/01/2021 because it was not time for it to be administered. EI #2 stated the record would not be considered complete and accurate if the medication was not documented on the MAR because facility policy was not followed. EI #2 stated if a record was not complete and accurate, it leaves a question whether the resident received or did not receive the medication as ordered.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 signed the narcotic log on 07/01/2021 that she pulled the Norco but it was not documented on the MAR since the MAR did not give an option to document since the medication was to be administered at 08:00AM and not 08:00PM. EI #1 stated the resident should receive the medication at the appropriate time given and the narcotic log and MAR should be signed.</p> <p>4.) RI #9 was admitted to the facility on 06/25/2021 with a readmission date of 06/30/2021.</p> <p>RI #9's Medication Review Report for July 2021 indicated Oxycodone HCl Tablet 5mg was ordered 06/29/2021 one by mouth every four hours as needed for severe pain and changed on 07/06/2021 to two tablets by mouth every four hours as needed for severe pain levels of five or greater on the pain scale. RI #9 was also ordered Restoril Capsule 30mg (Temazepam) on 07/01/2021, a capsule by mouth at bedtime as needed for three days and then one capsule by mouth as needed until 07/18/2021.</p> <p>A review of RI #9's Controlled Drug Record</p>	F 842			

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F 842	<p>Continued From page 12</p> <p>indicated EI #4, RN, administered Oxycodone HCl Tablet 5mg on 07/02/2021 at 09:00PM, 07/05/2021 at 04:00PM, 07/06/2021 at 04:00PM, 05:00PM and 09:00PM, 07/08/2021 at 8:30PM and 07/12/2021 at 03:30PM and 07:30PM. Documentation showed EI #4 also administered Temazepam 30mg on 07/05/2021 at 09:00PM, on 07/06/2021 at 09:00PM, on 07/10/2021 at 09:00PM, on 07/11/2021 at 09:15PM and on 07/12/2021 at 09:20PM.</p> <p>A review of RI #9's Medication Administration Record for July indicated EI #4 did not document administering Oxycodone HCl 5mg tablets to RI #9 on 07/02/2021 at 09:00PM, on 07/05/2021 at 04:00PM, on 07/06/2021 at 04:00PM, 05:00PM or 09:00PM, on 07/08/2021 at 8:30PM nor on 07/12/2021 at 03:30PM or 07:30PM. The MAR also indicated no documentation of EI #4 administering Temazepam 30mg on 07/05/2021 at 09:00PM, on 07/06/2021 at 09:00PM, on 07/10/2021 at 10:00PM, on 07/11/2021 at 09:15PM nor on 07/12/2021 at 09:20PM.</p> <p>In an interview on 10/26/2021 at 10:40AM, EI #3, ADON, stated EI #4 signed the narcotic log for the Oxycodone six different times but did not chart on the MAR. EI #3 stated EI #4 did not follow medication administration policy since she signed the narcotic log and not the MAR.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #4 signed the narcotic log for the Oxycodone on 07/02, 07/05, three times on 07/06, 07/08 and 07/12 but she did not chart on the MAR. EI #2 also reported EI #4 signed the narcotic log on 07/05, 07/06, 07/10, 07/11 and 07/12 for Restoril but she did not sign the MAR for those dates. EI #2 reported these were</p>	F 842			

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F 842	<p>Continued From page 13</p> <p>documentation issues because EI #4 did not chart on the MAR. EI #2 stated EI #4 should have documented on the narcotic log and once she administered the medication, she should have documented on the MAR that the resident took the medication. EI #2 stated EI #4 was educated on the policy prior to the incidents. EI #2 stated the record would not be considered complete and accurate because the nurse did not document the medication administration on the MAR. Facility policy was not followed. EI #2 stated if a record was not complete and accurate, it leaves a question whether the resident received or did not receive the medication as ordered.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 signed for the Oxycodone on the narcotic log on 07/02, 07/05, three times on 07/06 and 07/08, but did not sign the MAR. EI #4 also charted on the narcotic log on 07/12 for two doses but did not chart on the MAR. EI #1 also reported EI #4 signed the narcotic log on 07/05, 07/06, 07/10, 07/11 and 07/12 for the Restoril but EI #4 did not chart on the MAR. EI #1 stated these were inaccurate documentation issues because documentation on both the narcotic log and the MAR are required.</p> <p>5.) RI #10 was admitted to the facility on 05/01/2018 and readmitted 06/08/2020.</p> <p>RI #10's Medication Review Report for July 2021 indicated Acetaminophen-Codeine Tablet 300-30mg was ordered 11/08/2018 one tablet given every six hours as needed for severe pain.</p> <p>A review of RI #10's Controlled Drug Record indicated EI #4, RN, administered Tylenol with Codeine on 07/06/2021 at 07:00PM, 07/08/2021</p>	F 842			

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F 842	<p>Continued From page 14 at 09:00PM and 07/12/2021 at 10:00PM.</p> <p>A review of RI #10's Medication Administration Record for July 2021 indicated EI #4 did not document the administration of Tylenol with Codeine on 07/06/2021, 07/08/2021 nor 07/12/2021 at 10:00PM.</p> <p>An interview on 10/27/2021 at 09:29AM, EI #2, DON, stated EI #4 signed out the Tylenol with Codeine on the narcotic log 07/06, 07/08 and 07/12 but she did not document on the MAR. This was a documentation issue. EI #2 stated the medication was as needed so when the resident requested it, EI #4 should have gone to the narcotic box, removed the dose, ensured the count was correct, signed the narcotic log, administered to the patient and signed the MAR. EI #2 stated the record would not be considered complete and accurate if the MAR was not documented with the administration of the medication. EI #4 stated the facility's policies and procedures were not followed. EI #2 stated when a record was not complete and accurate, it leaves a question whether the resident received or did not receive the medication as ordered.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 documented Tylenol 3 on the narcotic log on 07/06, 07/08 and 07/12 but she did not chart on the MAR. EI #1 stated this was a documentation error.</p> <p>6.) RI #11 was admitted to the facility on 04/20/2018.</p> <p>RI #11's Medication Review Report for July indicated Tramadol HCl Tablet 50mg was ordered 08/06/2020 to be given my mouth as needed for</p>	F 842			

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F 842	<p>Continued From page 15 pain twice a day.</p> <p>A review of RI #11's Controlled Drug Record indicated EI #4 administered one 50mg tablet of Tramadol on 07/11/2021 at 04:25PM.</p> <p>A review of RI #11's Medication Administration Record indicated EI #4 did not document 50mg of Tramadol was administered on 07/11/2021.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #4 documented on the narcotic log on 07/11/2021 that she administered the Tramadol but EI #4 did not sign the MAR. EI #2 stated this was a documentation error. EI #2 stated the record would not be considered complete and accurate if the nurse did not document the administration on the MAR because the facility policy was not followed. EI #2 stated if a record was not complete and accurate, it leaves a question whether the resident received or did not receive the medication as ordered.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 signed out the Tramadol on the narcotic log on 07/11 but EI #4 did not sign the MAR. Error in documentation was identified. EI #1 stated EI #4 should have signed on the narcotic sheet and then documented administration on the MAR. EI #1 stated the record would have been complete and accurate if EI #4 had documented correctly but she did not. EI #1 stated the patient record was considered inaccurate. EI #1 stated a complete record is needed so the facility can determine whether they can provide a true assessment of the patient's care needs.</p> <p>7.) RI #2 was admitted to the facility on</p>	F 842			

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F 842	<p>Continued From page 16 10/14/2017 and readmitted 03/11/2021.</p> <p>RI #2's Medication Review Report for July 2021 indicated Marinol Capsule 2.5mg (Dronabinol) was ordered 06/24/2021 to be given by mouth two times a day for appetite for 30 days before morning and evening meals.</p> <p>A review of RI #2's Medication Administration Record indicated EI #4, RN, administered Marinol 2.5mg capsule on 07/01/2021 at 04:00PM.</p> <p>A review of RI #2's Controlled Drug Record did not reveal that EI #4 signed for the Dronabinol on 07/01/2021.</p> <p>In an interview on 10/26/2021 at 10:40AM, EI #3, ADON, reported EI #4 charted the Marinol as administered but EI #4 did not sign the narcotic log. EI #3 stated the facility policy is to sign both the narcotic log and the MAR.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #4 charted on the MAR on 07/01 that Marinol was administered but the narcotic log was not signed. EI #2 stated the medical record was not considered complete and accurate if the narcotic sheet was not signed. EI #2 stated this showed a discrepancy and left a question whether the resident received or did not receive the medication as ordered.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 signed on the MAR that the Marinol was administered but she did not sign the narcotic sheet. EI #1 stated this was a documentation error. EI #1 stated if the medication was not given, EI #4 should not have documented on the MAR.</p>	F 842			

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F 842	Continued From page 17 8.) RI #3's Medication Review Report for July 2021 indicated Restoril Capsule 15mg (Temazepam) was ordered 05/05/2021 to be given at bedtime for sleep. A review of RI #3's Medication Administration Record for July 2021 indicated EI #4, RN, administered Restoril 15mg capsule on 07/01/2021 at bedtime and on 07/11/2021 at bedtime. A review of RI #3's Controlled Drug Record did not reveal that EI #4 signed for the Restoril on 07/01/2021 nor 07/11/2021. In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #4 documented on the MAR on 07/01 and 07/11 that she gave the Restoril, but EI #4 did not sign out on the narcotic sheet. EI #2 stated this was a documentation issue because the medication was signed in one section but not the other. EI #2 stated she had questions when the Mar was signed but not the narcotic log because the MAR should be documented last in the process. EI #2 stated EI #4 should ensure she documented properly and she gave the medication. EI #2 stated the medical record was not considered complete and accurate if the narcotic sheet was not signed. EI #2 stated this showed a discrepancy and left a question whether the resident received or did not receive the medication as ordered. In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 documented Restoril on the MAR as administered on 07/01 and 07/11, but EI #4 did not sign on the narcotic log that the medication was administered. EI #1	F 842			

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F 842	<p>Continued From page 18</p> <p>stated this was a documentation issue. EI #1 stated EI #4 should have documented on the narcotic log and the MAR of the medication was administered.</p> <p>9.) RI #4 was admitted to the facility on 06/03/2021.</p> <p>RI #4's Medication Review Report for July 2021 indicated Xanax Tablet 0.5mg (Alprazolam) was ordered 06/10/2021 to be given four times a day for Anxiety with the last dose before bed.</p> <p>A review of RI #4's Medication Administration Record indicated EI #4, RN, signed for the Xanax on 07/02/2021 at evening and at bedtime and on 07/10/2021 at evening and at bedtime.</p> <p>A review of RI #4's Controlled Drug Record revealed that EI #4 signed for the Xanax on 07/02/2021 at 07:40PM but at no other time during her shift. EI #4 signed for the Xanax on 07/10/2021 at 09:15PM but at no other time during her shift.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #4 should have given the resident two doses during the 3-11 shift. EI #2 stated on 07/02, EI #4 documented two doses on the MAR but only signed the narcotic log at 07:40PM. EI #2 stated EI #4 did the same thing on 07/10, EI #4 charted two times on the MAR but only signed the narcotic sheet once at 09:00PM. EI #2 stated EI #4 should have removed the medication from the narcotic box, signed the narcotic sheet, taken the medication to the patient and signed the MAR. EI #2 stated the medical record was not considered complete and accurate if the narcotic sheet was not signed. EI</p>	F 842			

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F 842	<p>Continued From page 19</p> <p>#2 stated this showed a discrepancy and leaves a question whether the resident received or did not receive the medication as ordered.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 charted administration of the Xanax on 07/02 but EI #4 did not sign the narcotic log. EI #1 stated this was inaccurate documentation.</p> <p>10.) RI #5 was admitted to the facility on 11/17/2016 and readmitted 05/29/2021.</p> <p>RI #5's Medication Review Report for July 2021 indicated Hydrocodone-Acetaminophen Solution 7.5-325mg/15ml was ordered 06/09/2021 10ml to be given by mouth at bedtime for pain.</p> <p>A review of RI #5's Medication Administration Record indicated EI #4, RN, administered Hydrocodone-Acetaminophen Solution 07/02/2021 at bedtime, 07/05/2021 at bedtime and 07/12/2021 at bedtime.</p> <p>A review of RI #5's Controlled Drug Record did not indicate EI #4 signed for the Hydrocodone-Acetaminophen on 07/02/2021, 07/05/2021 nor 07/12/2021.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #4 charted on the MAR administering Norco on 07/02, 07/05 and 07/12 but EI #4 did not document it on the narcotic log. EI #2 stated the medical record was not considered complete and accurate if the narcotic sheet was not signed. EI #2 stated this showed a discrepancy and left a question whether the resident received or did not receive the</p>	F 842			

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F 842	<p>Continued From page 20 medication as ordered.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 charted on the MAR that Norco was administered 07/02, 07/05 and 07/12 but EI #4 did not document signing out the narcotic on the narcotic log. EI #1 stated this was a medication documentation error. EI #1 stated EI #4 should have provided the correct dose in the correct form and documented it on both the MAR and the narcotic log.</p> <p>11.) RI #7 was admitted to the facility on 02/20/2019 and readmitted 08/12/2019.</p> <p>RI #7's Medication Review Report for July 2021 indicated Neurontin Capsule 100mg (Gabapentin) was ordered 08/12/2019 to be given by mouth two times a day for neuropathy.</p> <p>A review of RI #7's Medication Administration Record indicated EI #4, RN, administered Neurontin 100mg the evening of 07/01/2021.</p> <p>A review of RI #7's Controlled Drug Record did not indicate EI #4 signed for the Neurontin on 07/01/2021.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #4 signed the MAR but not the narcotic sheet on 07/01 for the Neurontin. EI#2 stated EI #4 made documentation errors and the medication administration policy was not followed. EI #2 stated the medical record was not considered complete and accurate if the narcotic sheet was not signed. EI #2 stated this showed a discrepancy and left a question whether the resident received or did not receive the medication as ordered.</p>	F 842			

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F 842	Continued From page 21 In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 documented the Neurontin on the MAR on 07/01/2021, but EI #4 did not document on the MAR. 12.) RI #8's Medication Review Report for July 2021 indicated Gabapentin 400mg capsule was ordered 04/08/2018 to be given every 12 hours. A review of RI #8's Medication Administration Record for July 2021 indicated EI #4, RN, administered Gabapentin 400mg on 07/01/2021 at 08:00PM, 07/02/2021 at 08:00PM, 07/05/2021 at 08:00PM, 07/10/2021 at 08:00PM and 07/16/2021 at 08:00PM. A review of RI #8's Controlled Drug Record did not reveal that EI #4 signed for the Gabapentin on 07/01/2021, 07/02/2021, 07/05/2021, 07/10/2021 nor 07/16/2021. In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #4 documented the Neurontin on the MAR for 07/01, 07/02, 07/05 and 07/10 but did not sign the medication out on the narcotic log. EI #2 stated EI #4 should have signed out the medication on the narcotic log, taken the medication to the patient, and document on the MAR once the patient took the medication. EI #2 stated the medical record was not considered complete and accurate if the narcotic sheet was not signed. EI #2 stated this showed a discrepancy and leaves a question whether the resident received or did not receive the medication as ordered. In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported EI #4 documented on the	F 842			

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F 842	<p>Continued From page 22</p> <p>MAR the Neurontin was given 07/01, 07/02, 07/05 and 07/10 but EI #4 did not sign the narcotic log.</p> <p>13.) A review of RI #10's Medication Administration Record for July 2021 indicated EI #4, RN, administered Acetaminophen-Codeine 300-30mg on 07/11/2021 at 03:10PM, again at 03:10PM and a third time at 03:10PM, 03:15PM and 06:46PM. EI #4 also signed that she administered Acetaminophen-Codeine on 07/12/2021 at 03:12PM, 03:20PM and 04:22PM.</p> <p>A review of RI #10's Controlled Drug Record indicated EI #4 signed for Acetaminophen-Codeine on 07/11/2021 at 03:00PM. There were no other signatures for EI #4 on 07/11. EI #4 signed for Acetaminophen-Codeine on 07/12/2021 at 05:00PM and 10:00PM, but not for 03:12PM, 03:20PM nor 04:22PM.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported the times on the control sheet do not match the MAR. EI #2 stated EI #4 had extra sign out time on the MAR that was not on the narcotic sheet. EI #2 stated this was a documentation error. EI #2 stated if a patient asked for medication, EI #4 should have taken the narcotic out of the box, ensured the count was correct, signed the narcotic log, gave the medication to the patient and signed the MAR. EI #2 stated the medical record was not considered complete and accurate if the narcotic sheet was not signed. EI #2 stated this showed a discrepancy and leaves a question whether the resident received or did not receive the medication as ordered.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI#1,</p>	F 842			

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F 842	<p>Continued From page 23</p> <p>Administrator, reported EI #4 charted on the MAR on 07/11 four occurrences within the same timeframe which appeared to be duplicate entries and then one occurrence three hours later. EI #1 also stated EI #4 had duplicate entries on the MAR for 07/12 and only one signature on the narcotic log. EI #1 stated these were errors in documentation.</p> <p>14.) RI #1 was admitted to the facility on 12/02/2019.</p> <p>RI #1's Medication Review Report for July 2021 indicated Morphine Sulfate (Concentrate) Solution 20mg/ml was ordered 01/23/2020 to be given by mouth every hour as needed for pain/Dyspnea.</p> <p>A review of RI #1's Medication Administration Record indicated EI #4, RN, administered the medication on 07/02/2021 at 05:09PM.</p> <p>In an interview on 10/26/2021 at 10:40AM, EI #3, ADON, reported that EI #4 documented on the MAR that medication was given but the medication was not available to give and it had not been pulled from OMNICELL, which was the back-up medication supply. EI #3 stated EI #4 did not follow the facility's Controlled Medication Policy.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, Director of Nursing (DON), reported EI #4 charted on the MAR that Morphine Sulfate was administered on 07/02/2021 but the medication was not available to give nor was it removed from OMNICELL.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1,</p>	F 842			

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F 842	<p>Continued From page 24</p> <p>Administrator, reported EI #4 documented in the MAR that she administered a dose of Morphine but the medication was not removed and documented on the narcotic log. EI #1 stated the medication was available but was not pulled. EI #1 stated EI #4 should not have documented on the MAR if the resident did not receive the medication.</p> <p>15.) RI #12 was admitted to the facility on 06/18/2021.</p> <p>RI #12's Medication Review Report for July 2021 indicated Hydrocodone-Acetaminophen Tablet 7.5-325mg was ordered 06/18/2021 to be given every eight hours as needed for pain.</p> <p>A review of RI #12's Controlled Drug Record indicated EI #5, LPN, administered the Hydrocodone-Acetaminophen on 07/02/2021 at 08:00PM, 07/03/2021 at 06:00PM, 07/04/2021 at 08:00PM, 07/05/2021 at 08:00PM, 07/07/2021 at 08:30PM, 07/08/2021 at 08:00PM, 07/09/2021 at 08:00PM, 07/12/2021 at 08:30PM and 07/13/2021 at 07:00PM.</p> <p>A review of RI #12's Medication Administration Record revealed EI #5 did not document that she administered the Hydrocodone-Acetaminophen on 07/02/2021, 07/03/2021, 07/04/2021, 07/05/2021, 07/07/2021, 07/08/2021, 07/09/2021, 07/12/2021 nor 07/13/2021.</p> <p>In an interview on 10/26/2021 at 10:40AM, EI #3, ADON, reported an audit of all narcotics on carts in the facility revealed EI #5 pulled medication but did not document on the MAR. EI #3 stated EI #5 thought she was signing the sheet for both the count and the administration record. EI #3 stated</p>	F 842			

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F 842	<p>Continued From page 25</p> <p>EI #5 was not following the medication administration policy because she signed out the medication on the narcotic log but not the MAR.</p> <p>In a telephone interview on 10/27/2021 at 09:15AM, EI #5, LPN, reported she was busy and forgot to document on the MAR in July. EI #5 stated she was instructed to sign both the MAR and the narcotic book. EI #5 stated the resident's record was not complete and accurate if the MAR was not signed. EI #5 stated a complete and accurate record was needed so someone coming behind would know the medication had been administered. EI #5 stated she should have documented in the resident's MAR and the narcotic book.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #5 did sign the narcotic log but she did not sign the MAR. EI #2 stated EI #5 thought signing the narcotic log was sufficient. EI #2 stated the policy stated the narcotic log and the MAR were to be documented. EI #2 stated EI #5 received training on the policy at orientation. EI #2 stated the medical record was not complete because EI #5 did not complete both the narcotic sheet and the MAR. EI #2 stated the process was not complete and it could put into question which record was accurate. EI #2 stated when the resident asked for something for pain, EI #5 should have verified the order, taken out the amount into a cup, signed on the narcotic record and once the resident consumed the medication, recorded it on the MAR.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported an incorrect medication administration documentation error was identified because the narcotic log was signed but not the</p>	F 842			

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F 842	<p>Continued From page 26</p> <p>MAR. EI #1 stated the patient record was deemed inaccurate at that point. EI #1 stated a completed record was needed to determine whether the facility could provide a true assessment of the patient's care needs. EI #1 stated EI #5 should have documented the removal of the narcotic on the narcotic log and documented the administration of the narcotic on the MAR.</p> <p>16.) RI #13 was admitted to the facility on 06/03/2021 and readmitted 08/25/2021.</p> <p>RI #13's Medication Review Report for July 2021 indicated Norco Tablet 7.5-325mg (Hydrocodone-Acetaminophen) was ordered 06/24/2021 to be given every 12 hours as needed for pain.</p> <p>A review of RI #13's Controlled Drug Record indicated EI #5, LPN, administered Hydrocodone-Acetaminophen on 07/02/2021 at 08:00PM, 07/03/2021 at 08:00PM, 07/04/2021 at 08:00PM, 07/05/2021 at 08:00PM, 07/07/2021 at 07:00PM, 07/12/2021 at 07:00PM, 07/13/2021 at 06:00PM and 07/17/2021 at 07:00PM.</p> <p>A review of RI #13's Medication Administration Record indicated EI #5 did not sign that she administered Hydrocodone-Acetaminophen on 07/02/2021, 07/03/2021, 07/04/2021, 07/05/2021, 07/07/2021, 07/12/2021, 07/13/2021 nor 07/17/2021.</p> <p>In an interview on 10/26/2021 at 10:40AM, EI #3, ADON, reported an audit of all narcotics on carts revealed EI #5 pulled medication but did not sign the MAR. EI #3 stated EI #5 thought she was signing the sheet for both the count and the</p>	F 842			

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F 842	<p>Continued From page 27</p> <p>administration record. EI #3 stated EI #5 was not following the medication administration policy because she signed out the medication on the narcotic log but not the MAR.</p> <p>In a telephone interview on 10/27/2021 at 09:15AM, EI #5, LPN, reported she was busy and forgot to sign the MAR in July. EI #5 stated she was instructed to sign both the MAR and the narcotic book. EI #5 stated the resident's record was not complete and accurate if the MAR was not signed. EI #5 stated a complete and accurate record was needed so someone coming behind would know the medication had been administered. EI #5 stated she should have documented in the resident's MAR and the narcotic book.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #5 did sign the narcotic log but she did not sign the MAR. EI #2 stated EI #5 thought signing the narcotic log was sufficient. EI #2 stated the policy stated the narcotic log and the MAR were to be documented. EI #2 stated EI #5 received training on the policy at orientation. EI #2 stated the medical record was not complete because EI #5 did not complete both the narcotic sheet and the MAR. EI #2 stated the process was not complete and it could put into question which record was accurate. EI #2 stated when the resident asked for something for pain, EI #5 should have verified the order, taken out the amount into a cup, signed on the narcotic record and once the resident consumed the medication, recorded it on the MAR.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported an incorrect medication administration documentation error was identified</p>	F 842			

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F 842	<p>Continued From page 28</p> <p>because the narcotic log was signed but not the MAR. EI #1 stated the patient record was deemed inaccurate at that point. EI #1 stated a completed record was needed to determine whether the facility could provide a true assessment of the patient's care needs. EI #1 stated EI #5 should have documented the removal of the narcotic on the narcotic log and documented the administration of the narcotic on the MAR.</p> <p>17.) RI #14 was admitted to the facility on 06/28/2021.</p> <p>RI #14's Medication Review Report for July 2021 indicated Oxycodone HCl Tablet 5mg was ordered 06/28/2021 to be given every six hours as needed for moderate to severe pain.</p> <p>A review of RI #14's Controlled Drug Record indicated EI #5, LPN, administered Oxycodone on 07/02/2021 at 06:00PM, 07/03/2021 at 02:40PM, 07/03/2021 at 10:00PM, 07/04/2021 at 03:40PM, 07/04/2021 at 10:00PM, 07/05/2021 at 07:00PM, 07/07/2021 at 07:00PM, 07/08/2021 at ASH06:00PM, 07/09/2021 at 07:30PM, 07/12/2021 at 09:30PM and 07/13/2021 at 07:00PM.</p> <p>A review of RI #14's Medication Administration Record indicated EI #5 did not sign that she administered Oxycodone on 07/02/2021, 07/03/2021, 07/04/2021, 07/05/2021, 07/07/2021, 07/08/2021, 07/09/2021, 07/12/2021 nor on 07/13/2021.</p> <p>In an interview on 10/26/2021 at 10:40AM, EI #3, ADON, reported an audit of all narcotics on carts</p>	F 842			

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F 842	<p>Continued From page 29</p> <p>revealed EI #5 pulled medication but did not sign the MAR. EI #3 stated EI #5 thought she was signing the sheet for both the count and the administration record. EI #3 stated EI #5 was not following the medication administration policy because she signed out the medication on the narcotic log but not the MAR.</p> <p>In a telephone interview on 10/27/2021 at 09:15AM, EI #5, LPN, reported she was busy and forgot to sign the MAR in July. EI #5 stated she was instructed to sign both the MAR and the narcotic book. EI #5 stated the resident's record was not complete and accurate if the MAR was not signed. EI #5 stated a complete and accurate record was needed so someone coming behind would know the medication had been administered. EI #5 stated she should have documented in the resident's MAR and the narcotic book.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #5 did sign the narcotic log but she did not sign the MAR. EI #2 stated EI #5 thought signing the narcotic log was sufficient. EI #2 stated the policy stated the narcotic log and the MAR were to be documented. EI #2 stated EI #5 received training on the policy at orientation. EI #2 stated the medical record was not complete because EI #5 did not complete both the narcotic sheet and the MAR. EI #2 stated the process was not complete and it could put into question which record was accurate. EI #2 stated when the resident asked for something for pain, EI #5 should have verified the order, taken out the amount into a cup, signed on the narcotic record and once the resident consumed the medication, recorded it on the MAR.</p>	F 842			

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F 842	<p>Continued From page 30</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported an incorrect medication administration documentation error was identified because the narcotic log was signed but not the MAR. EI #1 stated the patient record was deemed inaccurate at that point. EI #1 stated a completed record was needed to determine whether the facility could provide a true assessment of the patient's care needs. EI #1 stated EI #5 should have documented the removal of the narcotic on the narcotic log and documented the administration of the narcotic on the MAR.</p> <p>18.) RI #15 was admitted to the facility on 07/10/2021.</p> <p>RI #15's Medication Review Report indicated Norco Tablet 5-325mg (Hydrocodone-Acetaminophen) was ordered 07/09/2021 to be given every eight hours as needed for pain for five days.</p> <p>A review of RI #15's Controlled Drug Record indicated EI #5, LPN, administered Hydrocodone-Acetaminophen on 07/12/2021 at 05:00PM and 07/13/2021 at 09:00PM.</p> <p>A review of RI #15's Medication Administration Record indicated EI #5 did not sign that she administered Hydrocodone-Acetaminophen on 07/12/2021 nor 07/13/2021.</p> <p>In an interview on 10/26/2021 at 10:40AM, EI #3, ADON, reported a house-wide audit revealed EI #5 pulled medication but did not sign the MAR. EI #3 stated EI #5 thought she was signing the sheet for both the count and the administration record. EI #3 stated EI #5 was not following the</p>	F 842			

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F 842	<p>Continued From page 31</p> <p>medication administration policy because she signed out the medication on the narcotic log but not the MAR.</p> <p>In a telephone interview on 10/27/2021 at 09:15AM, EI #5, LPN, reported she was busy and forgot to sign the MAR in July. EI #5 stated she was instructed to sign both the MAR and the narcotic book. EI #5 stated the resident's record was not complete and accurate if the MAR was not signed. EI #5 stated a complete and accurate record was needed so someone coming behind would know the medication had been administered. EI #5 stated she should have documented in the resident's MAR and the narcotic book.</p> <p>In an interview on 10/27/2021 at 09:29AM, EI #2, DON, reported EI #5 did sign the narcotic log but she did not sign the MAR. EI #2 stated EI #5 thought signing the narcotic log was sufficient. EI #2 stated the policy stated the narcotic log and the MAR were to be documented. EI #2 stated EI #5 received training on the policy at orientation. EI #2 stated the medical record was not complete because EI #5 did not complete both the narcotic sheet and the MAR. EI #2 stated the process was not complete and could be questionable which record was accurate. EI #2 stated when the resident asked for something for pain, EI #5 should have verified the order, taken out the amount into a cup, signed on the narcotic record and once the resident consumed the medication, recorded it on the MAR.</p> <p>In an interview on 10/27/2021 at 12:47PM, EI #1, Administrator, reported an incorrect medication administration documentation error was identified because the narcotic log was signed but not the</p>	F 842			

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F 842	<p>Continued From page 32</p> <p>MAR. EI #1 stated the patient record was deemed inaccurate at that point. EI #1 stated a completed record was needed to determine whether the facility could provide a true assessment of the patient's care needs. EI #1 stated EI #5 should have documented the removal of the narcotic on the narcotic log and documented the administration of the narcotic on the MAR.</p> <p>*****</p> <p>The facility implemented the following corrective actions:</p> <ul style="list-style-type: none"> *An investigation was conducted and EI #4 was suspended during the investigation. EI #4 was terminated 07/16/2021. *RI #9 and RI #10 were reimbursed the cost of their wasted medications. Completed 07/19/2021. *A house-wide audit completed 07/14/2021. *ADON notified the Medical Director on 07/13/2021. *Administrator notified the Pharmacy Consultant on 07/13/2021. *A Performance Improvement Plan was created and implemented. *All licensed nurses were re-educated on 07/13/2021 regarding Controlled Medication, Medication Storage and Medication Documentation and Administration. *EI #5 received one-on-one coaching regarding Medication Administration policy. Monthly medication pass observations for EI #5 began 07/2021 and will continue for six months. *Random Medication Pass Competencies on nurses were completed two times a week for four weeks and then weekly for four weeks. Completed 09/10/2021. 	F 842			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/27/2021
NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE CT SKILLED CARE CTR AT MAGNOLIA TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE ONE CROWN CIRCLE HUNTSVILLE, AL 35802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 842	Continued From page 33 *Narcotic Reconciliation Audits three times a week for four weeks, two times a week for four weeks and ongoing weekly. Two times a week completed 09/10/2021. Corrective actions began 07/13/2021 and were completed 09/10/2021. Therefore, past non-compliance was cited. ASHLEY TILL, SOCIAL WORKER	F 842			