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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT WAYNE - SNF	**493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470**

(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 COMPLAINT # NJ 95717, NJ 95718 CENSUS: 59 SAMPLE SIZE: 9	F 000		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: C# NJ 95717, C# NJ 95718 Based on observations, interviews, medical record (MR) review, and review of other pertinent facility documentation on 1/9/17 and 1/20/17, it was determined that the facility failed to follow their policy on re-ordering medications in advance to ensure availability of Schedule II (Dilaudid) and Schedule IV (Xanax) controlled medications for 4 of 9 sampled residents (Resident #5, #6, #7 and #8) which resulted in the borrowing of these controlled medications for 3 of 9 sampled residents (Resident #1, #2 and #3). In addition, the facility administered the borrowed controlled medications for 4 of 9 sampled residents (Resident #5, #6, #7 and #8). Furthermore, the facility failed to document the administration of Schedule II controlled substance medications (Dilaudid) on the Medication Administration Record (MAR) for 2 of 9 sampled residents	F 281	1.Residents # 1,2,3,5,6,7,8 have been discharged from COAW. 2.All Residents have the potential to be affected. Residents found in need of Schedule 1-5 control prescription or refill will be obtained by Physician to be sent to the Pharmacy to fill. 3.Facility educator/ designee will inservice licensed nurses regarding reordering of medications, obtaining of prescriptions for schedule 1-5 medications, non-borrowing policy, wasting procedure and documentation Medication Administration Record (MAR) to coincide with Controlled Drug Administration Record (CDAR)decline control accountability	2/16/17

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

Electronically Signed | 03/24/2017

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F 281	Continued From page 1 (Resident #6 and #7). This deficient practice is evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. According to the "Admission Record", Resident #1 was admitted on 8/8/16, and re-admitted on 10/22/16, with diagnoses that included but were not limited to; Diabetes Mellitus, Hypertension, Ischemic Heart Disease, and Anxiety. Resident #1 was discharged on 12/26/16. According to Resident #1's Minimum Data Set (MDS), an assessment tool dated 10/28/16, the	F 281	record. Unit Manager or designee will audit current residents with an order for Schedule 2 (Dilaudid) and Schedule 4 (Xanax) to ensure Individual Resident Prescription availability to dispense as prescribed in accordance with Physican Orders. Director of Nursing obtained DEA222 forms for Pyxis controlled medication ordering process to maintain a supply of Schedule 1-5 controlled medications in conjunction with Medical Directors. Inventory levels will be monitored for refill needs. Unit Manager or designee will continue to review residents for Medication Availability for administration daily Director of Nursing will continue to mnitor Pyxis inventory supply of Schedule 1-5 controls and replenish as needed. 4.DON/ UM/ Designees will conduct audits of 2 identified residents weekly for 3 months with an order for Schedule 2 (Dilaudid) and Schedule 4 (Xanax)for prescription availability, and proper documentation (MAR) coinciding with Controlled Drug Administration Record (CDAR). Findings will be presented at the Quality Assurance meeting held monthly and further recommendations by committee	

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resident had impaired short and long-term memory, and had impaired decision making ability.

According to the Physician's Orders dated 10/23/16, Resident #1 was prescribed Xanax 0.25 milligram (mg.) 1 tablet by mouth once a day. In addition, on 10/24/16, Xanax 0.25 mg 1 tablet by mouth every 6 hours as needed for anxiety was ordered.

According to Resident #1's December 2016 Medication Administration Record (MAR), the Xanax was documented as having been administered as ordered until 9:00 a.m. of 12/26/16, and was recorded on Resident #1's Controlled Drug Administration Record (CDAR).

On 1/9/17 at 10:05 a.m., an inspection of the Narcotic box inside the South Unit's Medication Cart (MC#3) was conducted with the Unit Manager/Registered Nurse (RN #1) and RN #2. The surveyor observed three Bingo cards (pop-out medication dispensing packages) of controlled drugs with a CDAR on each Bingo card, for three discharged Residents (Resident #1, #2 and #3).

The Bingo card for Resident #1 revealed that there were 13 tablets of Xanax 0.25 mg. left (not administered). A review of the CDAR for Resident #1's Xanax revealed four tablets were signed by RN #2 as wasted (disposed of). This same CDAR for Resident #1 revealed that there should have been 18 tablets of Xanax left instead of 13 tablets. The document attached to the CDAR revealed that five of Resident #1's remaining tablets of Xanax were used for two other residents (Resident #5 and #8).

will be made as needed.

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On 1/9/17 at 1:45 p.m., the Director of Nursing (DON) stated that RN #2 and Licensed Practical Nurse (LPN #1) were interviewed by the the Assistant Director of Nursing (ADON) on 1/9/17. The DON stated that RN #2 and LPN #1 informed the ADON that Resident #1's four tablets of Xanax were not wasted but were given to Resident #8 by RN #2. The DON stated that RN #2 and LPN #1 were given verbal warnings and provided with an In-service Education on 1/9/17, which included: "No borrowing" of any kind of medications, the physician would need to be notified for all controlled medications that would need prescriptions, the nurse should follow the " Medication Unavailable Flow Chart" to determine what to do, and all controlled medications that get wasted would need a witness.

An interview with RN #2 and LPN #1 was conducted on 1/9/17 at 3:20 p.m. RN #2 stated that Resident #1's Xanax was not wasted, but was borrowed and administered to Resident #8. RN #2 stated that she should not have borrowed Resident #1's Xanax for Resident #8 however, Resident #8 had no available medication at that time and there was none available in the Pyxis (an automated medication delivery cabinet used for emergency). RN #2 stated that she documented Resident #1's Xanax as wasted because she knew that the facility would not allow borrowing of medications.

During this interview, LPN #1 stated that she was present when RN #2 borrowed Resident #1's Xanax for Resident #8. LPN #1 also stated that RN #2 documented the 4 doses of 0.25 mg Xanax as wasted because the nurses were not supposed to borrow any medications.

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2. According to the "Admission Record", Resident #2 was admitted on 11/14/16, with diagnoses that included but were not limited to; Hernia Repair, Diabetes Mellitus, and Hypertension. Resident #2 was discharged on 11/19/16.

According to the Admission Assessment dated 11/14/16, Resident #2 was alert and oriented to person, place, and time.

According to the Physician's Orders dated 11/14/16, Resident #2 was on Dilaudid 2 mg. 1 tablet by mouth every 6 hours as needed for moderate pain.

A review of Resident #2's November 2016 MAR revealed that the resident was on Dilaudid 2 mg. 1 tablet by mouth every 6 hours as needed for moderate pain and documented that Resident #2 was administered this medication as ordered until 11/18/16 at 6:03 p.m., as well as recorded on Resident #2's CDAR.

On 1/9/17 at 10:05 a.m., an inspection of the Narcotic box inside the South Unit's MC#3 was conducted by the surveyor in the presence of RN #1 and RN #2.

The Bingo card for Resident #2 revealed that there was zero tablets left of Dilaudid 2 mg. (for pain) for Resident #2. A review of the CDAR for Resident #2's Dilaudid revealed that there should have been 26 tablets left instead of zero tablets. The document attached to the CDAR revealed that all of Resident #2's remaining tablets of Dilaudid were used for three other residents (Resident #6, #7 and #8).

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3. According to the "Admission Record" Resident #3 was admitted on 12/12/16, with diagnoses that included but were not limited to; Chronic Obstructive Pulmonary Disease, Hypertension, Fibromyalgia, and Anxiety. Resident #3 was discharged on 12/23/16.

According to Resident #3's MDS dated 12/18/16, the resident scored 15/15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact.

According to the Physician's Orders dated 12/12/16, Resident #3 was on Xanax 0.25 mg. 1 tablet by mouth every 4 hours as needed for Anxiety.

A review of Resident #3's December 2016 MAR revealed documentation that Resident #3 was administered this medication as ordered until 12/23/16 at 1:19 a.m. and was recorded on Resident #'3's CDAR.

On 1/9/17 at 10:05 a.m., an inspection of the Narcotic box inside the South Unit's MC#3 was conducted by the surveyor in the presence of the RN #1 and RN #2.

The Bingo card for Resident #3 revealed that there were 3 tablets left of Xanax 0.25 mg. for Resident #3. The CDAR for Resident #3's Xanax revealed that there should have been 16 tablets left instead of 3 tablets. The document attached to the CDAR revealed that thirteen of Resident #3's remaining tablets of Xanax were used for two other residents (Resident #5 and Resident #8).

4. According to the "Admission Record", Resident

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#5 was admitted on 12/13/16, with diagnoses that included but were not limited to; Right Hip Replacement, Hypertension, and Dementia. Resident #5 was discharged on 1/19/17.

Resident #5's MDS dated 12/19/16, revealed that the resident had impaired short term and long-term memory, and had impaired decision making ability.

According to the Physician's Orders dated 12/18/16, Resident #5 was on Xanax 0.25 mg. 1 tablet by mouth every 6 hours as needed.

A review of Resident #5's December 2016 and January 2017 MAR documented that Resident #5 was administered the Xanax as ordered until 1/15/17 at 5:17 p.m., which included documentation of the Xanax that was borrowed from Resident #1 on 1/2/17 at 12:00 a.m. and from Resident #3 on 12/25/16 at 7:11 p.m.

5. According to the "Admission Record" dated 12/22/16, Resident #6 was admitted with diagnoses that included but were not limited to; Vaginal and Cervical Cancer and Spinal Cord Compression. Resident #6 was discharged on 1/14/17.

According to Resident #6's MDS dated 12/29/16, the resident scored 15/15 on the BIMS which indicated the resident was cognitively intact.

According to the Physician's Orders dated 12/23/16, Resident #6 was on Dilaudid 2 mg. 1 tablet by mouth every 4 hours as needed for breakthrough pain. In addition, on 12/27/16, Dilaudid 2 mg. 1 tablet by mouth every 3 hours as needed for cancer pain was ordered.

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A review of Resident #6's December 2016 MAR revealed that the Dilaudid was not signed as having been administered by LPN #2, which would account for the Dilaudid borrowed from Resident #2 on 12/22/16 at 10:00 p.m., as recorded on Resident #2's CDAR. Resident #6's MAR also revealed that the Dilaudid was not signed as having been administered by RN #2, which would account for the Dilaudid borrowed from Resident #2 on 12/23/16 at 9:00 a.m., as recorded on Resident #2's CDAR.

A review of the Nurse's Note (NN) dated 12/22/16 at 11:17 p.m., signed by LPN #2 revealed: "Pain: Currently receives medication related to pain management."

A review of the NN dated 12/23/16 at 10:19 a.m., signed by RN #2, revealed that Resident #6 verbalized moderate pain on the left side of his/her body and Dilaudid was given with relief.

A post survey telephone interview was conducted by the surveyor on 1/25/17 at 2:00 p.m., with the DON. The DON confirmed that the Dilaudid borrowed from Resident #2 on 12/22/16 at 10:00 p.m., was not signed as having been administered by LPN #2 in Resident #6's MAR. The DON also verified that the Dilaudid borrowed from Resident #2 on 12/23/16 at 9:00 a.m., was not signed as having been administered by RN #2 in Resident #6's MAR.

During the same post survey telephone interview on 1/25/17 at 2:00 p.m., the DON explained that LPN #2 documented on his/her NN dated 12/22/16 at 11:17 p.m. that the Dilaudid was administered to Resident #6. The DON stated

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that LPN #2 was no longer employed in the facility. The DON further explained that RN #2 documented in his/her NN dated 12/23/16 at 10:19 a.m. that the Dilaudid was administered to Resident #6.

6. According to the "Admission Record" Resident #7 was admitted on 11/23/16, with diagnoses that included but were not limited to; Status Post Discitis with lower back pain, Diabetes Mellitus, Radiculopathy, and Hypertension. Resident #7 was discharged on 11/29/16.

The Physician's Orders dated 11/28/16, revealed an order for the resident for Dilaudid 2 mg. 1 tablet every 4 hours as needed for moderate pain and Dilaudid 2 mg. 2 tablets by mouth every 4 hours as needed for severe pain.

A review of Resident #7's November 2016 MAR revealed that the Dilaudid was not documented as administered by RN #3, which would account for the Dilaudid borrowed from Resident #2 on 11/24/16 at 4:00 a.m. and 11/29/16 at 7:30 a.m. The MAR also revealed that the Dilaudid was not documented as administered by LPN #3, which would account for the Dilaudid borrowed from Resident #2 on 11/24/16 at 9:55 a.m.

A post survey telephone interview was conducted by the surveyor on 1/25/17 at 2:00 p.m. with the DON. The DON confirmed that the Dilaudid borrowed from Resident #2 on 11/24/16 at 4:00 a.m., and 11/29/16 at 7:30 a.m., was not signed as having been administered by RN #3 in Resident #7's MAR. The DON also verified that the Dilaudid borrowed from Resident #2 on 11/24/16 at 9:55 a.m., was not signed as having been administered by LPN #3 in Resident #7's

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MAR.

A review of the facility's witness statement dated 1/26/17, written by LPN #3, revealed that LPN #3 administered Dilaudid 2 mg. to Resident #7 on 11/24/16 at 9:55 a.m., but forgot to sign the MAR.

A review of the facility's witness statement dated 2/9/17, written by RN #3, revealed that RN #3 administered Dilaudid 2 mg. to Resident #7 on 11/24/16 at 4:00 a.m. and 11/29/16 at 7:30 a.m., but forgot to sign the MAR.

7. According to the "Admission Record" dated 12/14/16, Resident #8 was admitted with diagnoses that included but were not limited to; Replacement of Infected Right Hip Prosthesis, Anxiety, and Hypertension. Resident #8 was discharged on 12/29/16.

According to Resident #8's MDS dated 12/21/16, the resident scored 14/15 on BIMS, which indicated the resident was cognitively intact.

According to the Physician's Orders dated 12/14/16, Resident #8 was on Dilaudid 2 mg. 1 tablet by mouth every 3 hours as needed for moderate pain and Dilaudid 4 mg. 1 tablet by mouth every 3 hours for severe pain. In addition, on 12/24/16, Resident #8 had an order for Xanax 0.5 mg. tablet 2 tablets by mouth every 12 hours for Anxiety.

Resident #8's December 2016 MAR documented that Resident #8 was administered this medication as ordered until 12/29/16 at 9:00 p.m., which included the Xanax borrowed from Resident #1 on 12/28/16 at 9:00 p.m., and the Xanax borrowed from Resident #3 at 9:00 a.m.

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on 12/24, 12/25, 12/26, and 12/27/16.

Further review of the MAR revealed that the resident was on Dilaudid 2 mg. 1 tablet by mouth every 3 hours as needed for moderate pain and Dilaudid 4 mg. 1 tablet by mouth every 3 hours for severe pain. This MAR documented that Resident #8 was administered this medication as ordered which included the Dilaudid that was borrowed from Resident #2 on 12/14/16 at 4:13 p.m., on 12/14/16 at 7:40 p.m., and on 12/15/16 at 4:56 a.m.

When interviewed on 1/9/17 at 10:45 a.m., RN #1 stated that the medication nurses should re-order medications as soon as it reached the blue line (eight pills left) indicated on the Bingo card to ensure availability of medications. RN #1 further stated that the nurses were not allowed to borrow medications.

The surveyor conducted an interview on 1/9/17 at 11:35 a.m. with the DON. The DON stated that she was not aware that there were three bingo cards of controlled drugs from three discharged residents inside the narcotic box of MC #3 until the day of the survey (1/9/17). The DON stated that she was also not aware that the nurses were borrowing these controlled drugs and had administered the controlled drugs to other residents.

The DON further stated that the facility did not have a policy for borrowing medication because the Nursing staff were not allowed to borrow any medications from a resident to be given to another resident. The DON stated that in case a resident had an order for any medication that was not available or would only be available at a later

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time, the nurses should call the doctor to change the medication, should request the Pharmacy provider for a stat delivery, should call another Pharmacy or in case of emergency, use the Pyxis. The DON stated that the Attending Medical Doctor (AMD) was responsible for issuing prescriptions for controlled drugs, and that whenever the AMD of a resident would not be able to issue the Prescription for the controlled drug in a timely manner for any reason, there was a Physiatrist available to issue the Prescription. The DON stated that the Pyxis was only used for an emergency.

When interviewed by the surveyor on 1/9/17 at 1:00 p.m., the Physiatrist stated that if and when the AMD would not be able to write a prescription for a controlled drug for a resident promptly, the facility would ask him to assess the resident and he would issue the prescription if medically necessary.

When interviewed by the surveyor on 1/20/17 at 12:45 p.m., the DON stated that the facility's Pharmacy Provider delivered twice a day, the first delivery was early in the morning before the end of 11:00 p.m. - 7:00 a.m. (11-7) shift and the second delivery was later in the evening before the end of the 3:00 p.m. -11:00 p.m. (3-11) shift.

When further interviewed by the surveyor, the DON stated that the facility has a Pharmacy Consultant (PC) not affiliated with their Pharmacy Provider. The DON stated that the PC would come to the facility every month and was in the facility on 1/19/17.

When interviewed by the surveyor on 1/20/17 at 2:00 p.m., the PC stated that they were not

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affiliated with the facility's Pharmacy Provider. The PC stated that they would go to the facility every month and would conduct Drug Regimen Review, would ensure that systems/processes were in place for proper storage, labeling, administration, disposition of medication amongst other things required by local, state and federal law. The PC further stated that if and when medications ordered were not available, the staff should call the facility's Pharmacy provider for a stat delivery, or call the facility's alternate Pharmacy or call the AMD for possible medication order change.

A review of the "Nursing News Letter" dated 12/30/16, revealed a reminder for all nurses that the medication availability form should be completed every shift and the supervisor should be notified for any missing medications. This newsletter also indicated that nurses should follow the "Medication Unavailable Flow Chart" which guides the staff on what to do when medications where not available. The News letter also directed that all staff must observe compliance with the controlled drugs inventory count every shift.

A review of the In-service Education Record revealed that on 1/9/17, the facility provided an In-service education about "No borrowing" of any kind of medications. This In-service education also included the following: the AMD would need to be notified on time for all controlled medications that would need prescription, the nurse should follow the medications " Medication Unavailable Flow Chart" to determine what to do.

A review of the cautionary instruction written on the label attached to the CDAR revealed:

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F 281	Continued From page 13 "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed." A review of the undated facility's Policy titled "Documentation on Medication Administration Record" revealed that the facility should maintain the medication administration record to document all medications administered. The policy explained that the Nurse should document all medications administered to each resident's Medication Administration Record (MAR). It also explained that the documentation must include, as a minimum: (f.) signature and title of the person administering the medication. A review of the undated facility's Policy titled " Medication orders and Receipt Record" revealed that the Director of Nursing Services would designate individuals to be responsible for completing medication order/receipt forms and medications should be ordered in advance, based on the dispensing pharmacy's required lead time.	F 281		
F 431 SS=E	NJ 8:39-29.2(a) NJ 8:39-29.2(d) 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 431		2/16/17

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supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the

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F 431	Continued From page 15 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: C# NJ 95717, C# NJ 95718 Based on observation, interviews, medical record (MR) review, and review of other pertinent facility documentation on 1/9/17 and 1/20/17, it was determined that the facility failed to ensure that all nursing staff performed accurate reconciliation and accounting of Schedule II (Duragesic Patch) and Schedule IV (Xanax) Controlled medications for 2 of 9 sampled residents (Resident #1 and #9). In addition, the facility failed follow facility policy to remove controlled medications in a timely manner (Dilaudid and Xanax) for residents that were discharged from the facility for 3 of 9 sampled residents (Resident #1, #2 and #3), and failed to follow facility policy when Nursing Staff borrowed Dilaudid and Xanax for 3 of 9 sampled residents (Resident #1, #2 and #3) and administered these controlled medications to 4 of 9 sampled residents (Resident #5, #6, #7 and #8). Furthermore, the facility Nursing staff failed to document proper witnessed disposal of controlled medications for 1 of 9 sampled residents (Resident #1). This deficient practice is evidenced by the following: 1. According to the "Admission Record", Resident #1 was admitted on 8/8/16, and re-admitted on 10/22/16, with diagnoses that included but were not limited to; Diabetes Mellitus, Hypertension,	F 431	1.Residents noted in survey sample have been discharged from COAW. 2.All Residents have the potential to be affected. 3.The Facility educator (FE) or designee will inservice licensed nurses regarding wasting procedure for controlled medication including the need for a witness and documentation on Control Administration Declining Record (CDAR) The FE/ ADON or designee will audit medication carts weekly for removal of discharged medications and controlled medication following the destruction procedure. The Director of Nursing (DON)or designee conducted an audit 1/9/17 and ongoing of current residents to evaluate Control Administration Declining. 4.The Unit Managers (UM) or designee will audit current Control Declining Administration Records (CDAR) for 2 residents weekly for 3 months for compliance. The FE/ADON, UM or designee will audit	

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Ischemic Heart Disease, and Anxiety. Resident #1 was discharged on 12/26/16.

According to Resident #1's Minimum Data Set (MDS), an assessment tool dated 10/28/16, the resident had impaired short and long-term memory and had impaired decision making ability.

According to the Physician's Orders dated 10/23/16, Resident #1 was on Xanax 0.25 milligram (mg.) 1 tablet by mouth once a day. In addition, on 10/24/16, Xanax 0.25 mg 1 tablet by mouth every 6 hours as needed for anxiety was ordered.

According to Resident #1's December 2016 Medication Administration Record (MAR), the Xanax was documented as having been administered as ordered until 9:00 a.m. on 12/26/16, and was recorded on Resident #1's Controlled Drug Administration Record (CDAR).

On 1/9/17 at 10:05 a.m., an inspection of the Narcotic box inside the South Unit's Medication Cart (MC#3) was conducted with the Unit Manager/Registered Nurse (RN #1) and RN #2. The surveyor observed three Bingo cards (pop-out medication dispensing packages) of controlled medications, with a CDAR for each Bingo card, for three discharged Residents (Resident #1, #2 and #3).

The Bingo card for Resident #1 revealed that there were 13 tablets of Xanax 0.25 mg. left. A review of the CDAR for Resident #1's Xanax revealed four tablets were wasted (disposed of) and signed by one nurse (RN #2). This same CDAR for Resident #1 revealed that there should

medication carts for timely removal of discharged medications daily x 3 weeks then weekly for 3 months.

Findings will be presented at the Quality Assurance meeting held monthly and further recommendations by committee will be made as needed.

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have been 18 tablets of Xanax instead of 13 tablets. The document attached to the CDAR revealed that five of Resident #1's remaining tablets of Xanax were used for two other residents (Resident #5 and #8).

The surveyor conducted an interview with RN #2 on 1/9/17 at 10:30 a.m. RN #2 stated that Resident #1 was discharged and that the four tablets of Xanax were wasted because the resident refused the medications. RN #2 stated that the controlled drugs for discharged residents were kept in the narcotic box inside the medication cart until the supervisor destroyed it with another nurse.

On 1/9/17 at 1:45 p.m., the Director of Nursing (DON) stated that RN #2 and Licensed Practical Nurse (LPN #1) were interviewed by the the Assistant Director of Nursing (ADON) on 1/9/17. The DON stated that RN #2 and LPN #1 informed the ADON that Resident #1's four tablets of Xanax were not wasted but were given to Resident #8 by RN #2. The DON stated that RN #2 and LPN #1 were given verbal warnings and provided with an In-service Education on 1/9/17, which included: "No borrowing" of any kind of medications, the physician would need to be notified on time for all controlled medications that would need prescriptions, the nurse should follow the "Medication Unavailable Flow Chart" to determine what to do, and all controlled medications that get wasted would need a witness.

An interview with RN #2 and LPN #1 was conducted on 1/9/17 at 3:20 p.m. RN #2 stated that Resident #1's Xanax was not wasted but was borrowed and administered for Resident #8. RN

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#2 stated that she should not have borrowed Resident #1's Xanax for Resident #8 however, Resident #8 had no available medication at that time and there was none available in the Pyxis (an automated medication delivery cabinet used for emergency). RN #2 stated that she documented Resident #1's Xanax was wasted because he/she knew that the facility would not allow borrowing of medications.

During this interview, LPN #1 stated that she was present when RN #2 borrowed Resident #1's Xanax for Resident #8. LPN #1 stated that RN #2 documented the 4 doses of 0.25 mg Xanax as wasted because the nurses were not supposed to borrow any medications. LPN #1 further stated that it was the facility's policy to witness and document disposal of narcotics by two licensed nurses.

2. According to the "Admission Record", Resident #2 was admitted on 11/14/16, with diagnoses that included but were not limited to; Hernia Repair, Diabetes Mellitus, and Hypertension. Resident #2 was discharged on 11/19/16.

According to Resident #2's Admission Assessment dated 11/14/16, the resident was alert and oriented to person, place, and time.

According to the Physician's Orders for Resident #2 dated 11/14/16, the resident was on Dilaudid 2 mg. 1 tablet by mouth every 6 hours as needed for moderate pain.

A review of Resident #2's November 2016 MAR revealed that the resident was on Dilaudid 2 mg. 1 tablet by mouth every 6 hours as needed for moderate pain. This MAR revealed that Resident

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#2 was administered this medication as ordered until 11/18/16 at 6:03 p.m., and it was recorded on Resident #2's CDAR.

On 1/9/17 at 10:05 a.m., an inspection of the Narcotic box inside the South Unit's MC#3 was conducted by the surveyor in the presence of RN #1 and RN #2.

The Bingo card for Resident #2 revealed that there were zero tablets left of Dilaudid 2 mg. (for pain) for Resident #2. A review of the CDAR for Resident #2's Dilaudid revealed that there should have been 26 tablets left instead of zero. The document attached to the CDAR revealed that all of Resident #2's remaining tablets of Dilaudid were used for three other residents (Resident #6, #7 and #8).

3. According to the "Admission Record", Resident #3 was admitted on 12/12/16, with diagnoses that included but were not limited to; Chronic Obstructive Pulmonary Disease, Hypertension, Fibromyalgia, and Anxiety. Resident #3 was discharged on 12/23/16.

According to Resident #3's MDS dated 12/18/16, the resident scored 15/15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact.

According to the Physician's Orders for Resident #3 dated 12/12/16, the resident was on Xanax 0.25 mg. 1 tablet by mouth every 4 hours as needed for Anxiety.

A review of Resident #3's December 2016 MAR revealed that the resident was on Xanax 0.25 mg. 1 tablet by mouth every 4 hours as needed for

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anxiety. This MAR revealed that Resident #3 was administered this medication as ordered until 12/23/16 at 1:19 a.m., and it was recorded on Resident #'3's CDAR.

On 1/9/17 at 10:05 a.m., an inspection of the Narcotic box inside the South Unit's MC#3 was conducted by the surveyor in the presence of the RN #1 and RN #2.

The Bingo card for Resident #3 revealed that there were 3 tablets left of Xanax 0.25 mg. for Resident #3. The CDAR for Resident #3's Xanax revealed that there should have been 16 tablets left instead of 3 tablets. The document attached to the CDAR revealed that thirteen of Resident #3's remaining tablets of Xanax were used for two other residents (Resident #5 & #8).

4. According to the "Admission Record", Resident #5 was admitted on 12/13/16, with diagnoses that included but were not limited to; Right Hip Replacement, Hypertension, and Dementia. Resident #5 was discharged on 1/19/17.

Resident #5's MDS dated 12/19/16, revealed that the resident had impaired short term and long-term memory, and had impaired decision making ability.

According to the Physician's Orders for Resident #5 dated 12/18/16, the resident was on Xanax 0.25 mg. 1 tablet by mouth every 6 hours as needed.

A review of Resident #5's December 2016 and January 2017 MAR revealed that the resident had an order for Xanax 0.25 mg. 1 tablet by mouth every 6 hours as needed. The MARs revealed

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that Resident #5 was administered the Xanax as ordered until 1/15/17 at 5:17 p.m., which included the Xanax that was borrowed from Resident #1 on 1/2/17 at 12:00 a.m., and from Resident #3 on 12/25/16 at 7:11 p.m.

5. According to the "Admission Record", Resident #6 was admitted on 12/22/16, with diagnoses that included but were not limited to; Vaginal and Cervical Cancer, and Spinal Cord Compression. Resident #6 was discharged on 1/14/17.

According to Resident #6's MDS dated 12/29/16, the resident scored 15/15 on the BIMS, which indicated the resident was cognitively intact.

According to the Physician's Orders for Resident #6, dated 12/23/16, the resident was on Dilaudid 2 mg. 1 tablet by mouth every 4 hours as needed for breakthrough pain. In addition, on 12/27/16, Dilaudid 2 mg. 1 tablet by mouth every 3 hours as needed for cancer pain was ordered.

A review of Resident #6's December 2016 MAR revealed that the Dilaudid was not signed as having been administered by LPN #2, which would account for the Dilaudid borrowed from Resident #2 on 12/22/16 at 10:00 p.m., as recorded on Resident #2's CDAR. Resident #6's MAR also revealed that the Dilaudid was not signed as having been administered by RN #2, which would account for the Dilaudid borrowed from Resident #2 on 12/23/16 at 9:00 a.m., as recorded on Resident #2's CDAR.

A review of the Nurse's Note (NN) dated 12/22/16 at 11:17 p.m., signed by LPN #2, revealed: "Pain: Currently receives medication related to pain management."

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A review of the NN dated 12/23/16 at 10:19 a.m., signed by RN #2, revealed that Resident #6 verbalized moderate pain on the left side of his/her body and Dilaudid was given with relief.

A post survey telephone interview was conducted by the surveyor on 1/25/17 at 2:00 p.m., with the DON. The DON confirmed that the Dilaudid borrowed from Resident #2 on 12/22/16 at 10:00 p.m., was not signed as having been administered by LPN #2 in Resident #6's MAR. The DON also verified that the Dilaudid borrowed from Resident #2 on 12/23/16 at 9:00 a.m., was not signed as having been administered by RN #2 in Resident #6's MAR.

During the same post survey telephone interview on 1/25/17 at 2:00 p.m., the DON explained that LPN #2 documented on his/her NN dated 12/22/16 at 11:17 p.m., that the Dilaudid was administered to Resident #6. The DON stated that LPN #2 was no longer employed in the facility. The DON further explained that RN #2 documented in his/her NN dated 12/23/16 at 10:19 a.m., that the Dilaudid was administered to Resident #6.

6. According to the "Admission Record", Resident #7 was admitted on 11/23/16, with diagnoses that included but were not limited to; Status Post Discitis with lower back pain, Diabetes Mellitus, Radiculopathy, and Hypertension. Resident #7 was discharged on 11/29/16.

The Physician's Orders for Resident #7 dated 11/28/16, revealed an order for Dilaudid 2 mg. 1 tablet every 4 hours as needed for moderate pain and Dilaudid 2 mg. 2 tablets by mouth every 4

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hours as needed for severe pain.

A review of Resident #7's November 2016 MAR revealed that the Dilaudid was not documented as administered by RN #3, which would account for the Dilaudid borrowed from Resident #2 on 11/24/16 at 4:00 a.m., and 11/29/16 at 7:30 a.m. The MAR also revealed that the Dilaudid was not documented as administered by LPN #3, which would account for the Dilaudid borrowed from Resident #2 on 11/24/16 at 9:55 a.m.

A post survey telephone interview was conducted by the surveyor on 1/25/17 at 2:00 p.m. with the DON. The DON confirmed that the Dilaudid borrowed from Resident #2 on 11/24/16 at 4:00 a.m. and 11/29/16 at 7:30 a.m., was not signed as having been administered by RN #3 in Resident #7's MAR. The DON also verified that the Dilaudid borrowed from Resident #2 on 11/24/16 at 9:55 a.m. was not signed as administered by LPN #3 in Resident #7's MAR.

A review of the facility's witness statement dated 1/26/17, written by LPN #3, revealed that LPN #3, administered Dilaudid 2 mg. to Resident #7 on 11/24/16 at 9:55 a.m., but forgot to sign the MAR.

A review of the facility's witness statement dated 2/9/17, written by RN #3, revealed that RN #3 administered Dilaudid 2 mg. to Resident #7 on 11/24/16 at 4:00 a.m., and 11/29/16 at 7:30 a.m., but forgot to sign the MAR.

7. According to the "Admission Record", Resident #8 was admitted on 12/14/16, with diagnoses that included but were not limited to; Replacement of Infected Right Hip Prosthesis, Anxiety, and Hypertension. Resident #8 was discharged on

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12/29/16.

According to Resident #8's MDS dated 12/21/16, the resident scored 14/15 on the BIMS, which indicated the resident was cognitively intact.

According to the Physician's Orders for Resident #8 dated 12/14/16, the resident was on Dilaudid 2 mg. 1 tablet by mouth every 3 hours as needed for moderate pain and Dilaudid 4 mg. 1 tablet by mouth every 3 hours for severe pain. In addition, on 12/24/16, Resident #8 had an order for Xanax 0.5 mg. tablet 2 tablets by mouth every 12 hours for Anxiety.

Resident #8's December 2016 MAR revealed that the resident was on Xanax 0.5 mg. tablet 2 tablets by mouth every 12 hours for Anxiety. This MAR revealed that Resident #8 was administered this medication as ordered until 12/29/16 at 9:00 p.m., which included the Xanax 1 mg. borrowed from Resident #1 on 12/28/16 at 9:00 p.m., and the Xanax borrowed from Resident #3 at 9:00 a.m. on 12/24, 12/25, 12/26, and 12/27/16.

Further review of this MAR revealed that the resident was on Dilaudid 2 mg. 1 tablet by mouth every 3 hours as needed for moderate pain and Dilaudid 4 mg. 1 tablet by mouth every 3 hours for severe pain. This MAR revealed that Resident #8 was administered this medication as ordered, which included the Dilaudid that was borrowed from Resident #2 on 12/14/16 at 4:13 p.m., on 12/14/16 at 7:40 p.m., and on 12/15/16 at 4:56 a.m.

A review of the Precautionary warning written on the label attached to the CDAR revealed: "Caution: Federal law prohibits the transfer of this

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drug to any person other than the patient for whom it was prescribed."

When interviewed on 1/9/17 at 10:45 a.m., RN #1 stated that all controlled medications for discharged residents were kept locked in the narcotic box inside the medication cart until the supervisor destroyed it with another nurse. RN #1 stated that the controlled medications for discharged residents should be destroyed right away, and that two nurses were required to sign when controlled medications were wasted and/or destroyed. RN #1 stated that the medication nurses should re-order medications as soon as it reached the blue line (eight pills left) indicated on the Bingo card to ensure availability of medications. RN #1 further stated that the nurses were not allowed to borrow medications.

The surveyor conducted an interview on 1/9/17 at 11:35 a.m., with the DON. The DON stated that she was not aware that there were three bingo cards of controlled medications from three discharged residents inside the narcotic box of MC #3 until the day of the survey (1/9/17). The DON stated that she was also not aware that the nurses were borrowing these controlled medications and had administered them to other residents.

The DON further stated that the facility did not have a policy for borrowing medication because the Nursing staff were not allowed to borrow any medications from a resident to be given to another resident. The DON stated that in case a resident had an order for any medication that was not available or would only be available at a later time, the nurses should call the doctor to change the medication, should request the Pharmacy

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provider for a stat delivery, should call another Pharmacy or in case of emergency use the Pyxis. The DON stated that the Attending Medical Doctor (AMD) was responsible for issuing prescriptions for controlled drugs and that whenever the AMD of a resident would not be able to issue the Prescription for the controlled drug in a timely manner for any reason, there was a Physiatrist available to issue the Prescription. The DON stated that the Pyxis was only used for an emergency.

When interviewed by the surveyor on 1/9/17 at 1:00 p.m., the Physiatrist stated that if and when the AMD would not be able to write a prescription for a controlled drug for a resident promptly, the facility would ask him to assess the resident and he would issue the prescription if medically necessary.

When interviewed by the surveyor on 1/20/17 at 12:45 p.m., the DON stated that the facility had no time frame as to when to destroy controlled drugs for discharged residents. The DON stated that it should remain in the medication cart under double lock until removed by the Nursing Supervisor for destruction by two Nursing staff. The DON stated that the frequency of controlled drugs destruction depends on how many controlled drugs were needed to be destroyed.

During this interview with the surveyor, the DON stated that the facility's Pharmacy Provider delivered twice a day, the first delivery would be early in the morning before the end of 11:00 p.m. - 7:00 a.m. (11-7) shift, and the second delivery would be later in the evening before the end of the 3:00 p.m. -11:00 p.m. (3-11) shift.

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8. According to the "Admission Record", Resident #9 was admitted on 11/19/16, with diagnoses that included but were not limited to; Cardiovascular Accident, Hypertension, Anxiety, and Left Buttock Stage 3 Pressure Sore.

According to Resident #9's MDS dated 11/26/16, the resident scored 13/15 on the BIMS, which indicated that the resident was cognitively intact.

According to the Physician's Orders for Resident #9 dated, the resident was on Duragesic Patch 12 micrograms (mcg) per hour (hr), changed every 72 hours for pain.

A review of Resident #9's January 2017 MAR revealed that Resident #9 received this Duragesic patch 12 mcg/hr on 1/19/17 at 5:00 p.m. The CDAR was also reviewed and revealed that RN #4 did not sign for the medication on the CDAR.

On 1/20/17 at 10:50 a.m., an inspection of the Narcotic box inside the South Unit's MC #4 was conducted by the surveyor in the presence of RN #1. The surveyor observed 2 boxes of Duragesic Patch inside a plastic bag labeled with Resident #9's name, 1 opened and 1 unopened. RN#1 verified that the Duragesic patches were ordered for Resident #9. RN #1 showed the surveyor four patches of Duragesic 12 mcg/hr. from the opened box. The CDAR for the opened box revealed that there should have been 5 patches in the box. RN #4 did not sign out on the CDAR the usage of one Duragesic Patch 12 mcg/hr. on 1/19/17 at 5:00 p.m.

A review of the individual statement form written by LPN #4 dated 1/20/17, untimed, revealed that LPN #4 counted narcotics with the outgoing 11:00

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p.m. - 7:00 a.m. (11-7) shift, except for the Duragesic patch. The statement revealed that this was not the LPN #4's usual practice.

When interviewed by the surveyor on 1/20/17 at 10:45 a.m., LPN #4 stated that a Narcotic count was conducted the morning of 1/20/17, between the outgoing 11:00 p.m. - 7:00 a.m. (11-7) shift and the incoming 7:00 a.m. - 3:00 p.m. (7-3) shift. LPN #4 stated that he/she did not count the Duragesic patches because he/she thought the box was not opened.

When interviewed by the surveyor on 1/20/17 at 11:35 a.m., RN #4 stated that he/she applied one patch of Duragesic patch 12 mcg/hr. to Resident #9's right chest wall on 1/19/17 at 5:00 p.m. RN #4 stated that he/she was about to sign the CDAR but was called to attend to an agitated resident and had forgotten to sign. RN#4 stated that a Narcotic count was conducted between 3:00 p.m. -11:00 p.m. (3-11) shift and the incoming 11:00 p.m. - 7:00 p.m. shift, but forgot to count the Duragesic patches. RN#4 stated that this was the first time she missed signing the CDAR.

When interviewed by the surveyor on 1/20/17 at 12:45 p.m., the DON stated that the nurses should conduct narcotic count between the incoming and outgoing shifts and whenever there would be a turn-over between the medication nurses. The DON stated the narcotic count also included the controlled substances in the Pyxis.

When further interviewed by the surveyor, the DON stated that the facility has a Pharmacy Consultant (PC) not affiliated with their Pharmacy Provider. The DON stated that the PC would

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come to the facility every month and was in the facility on 1/19/17.

When interviewed by the surveyor on 1/20/17 at 2:00 p.m., the PC verified that they were not affiliated with the facility's Pharmacy Provider. The PC stated that they would go to the facility every month and would conduct Drug Regimen Review, would ensure that systems/processes were in place for proper storage, labeling, administration, disposition of medication amongst other things required by local, state and federal law.

During this interview with the surveyor, the PC informed the surveyor that medications for discharged residents were not removed from the South Unit Medication Cart for November and December 2016. The PC stated she was not able to identify whose and what medications were not removed but it should be written in the PC's Inspection report. The PC stated that they would document their findings during their monthly visit and would give it to the DON. The PC further stated that she would also talk to the nurses and DON about their findings. The PC explained that the DON was very involved and addressed their concerns and recommendations promptly. The PC further stated that if and when medications ordered were not available, the staff should call the facility's Pharmacy provider for a stat delivery, or call the facility's alternate Pharmacy or call the AMD for possible medication order change. The PC also stated that although the facility had no time frame for disposal of controlled medications, the facility should immediately remove all medications and disposed controlled medications of discharged residents to prevent medication error and borrowing. The PC further explained

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that it was not a good practice to keep controlled medications more than a month after a resident was discharged.

A review of the Pharmacy Consultant's Unit Inspection Report from November 2016 to January 2017 revealed the following: 1. The Inspection Report for South Unit dated 11/29/16, revealed that the discontinued medications were not removed in the medication cart, controlled drugs inventory count each shift was not done for certain days, the declining inventory for one of the residents (not in the sample) was incorrectly signed and the Pyxis shift to shift narcotic count was missing. 2. The Inspection report dated 12/28/16, revealed that discontinued medications were not removed from the North and South Unit medication carts, controlled drugs inventory count each shift was not done for certain days on both units, there were missing nurses signature on both unit's narcotic shift to shift form, a controlled drug from discharged (not in the sample) residents were not removed in the South unit and Pyxis shift to shift narcotic count was missing. 3. The report dated 1/19/17, revealed that discontinued medications were not removed from the North and South Unit medication carts.

A review of "Nursing News Letter" dated 11/30/16, revealed a reminder for all nurses to observe compliance with controlled drugs inventory count every shift.

A review of the "Nursing News Letter" dated 12/30/16, revealed a reminder for all nurses that the medication availability form should be completed every shift and the supervisor should be notified for any missing medications. This newsletter also indicated that nurses should

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follow the "Medication Unavailable Flow Chart" which guide the staff on what to do when medications where not available. The News letter also directed that all staff must observe compliance with controlled drugs inventory count every shift.

A review of the In-service Education Record revealed that on 1/9/17, the facility provided an In-Service Education which included: "No borrowing" of any kind of medications, the AMD would need to be notified on time for all controlled medications that would need prescription, the nurse should follow the " Medication Unavailable Flow Chart" to determine what to do, and all controlled medications that get wasted would need a witness.

A review of the In-Service Education Record dated 1/20/17, the day of the survey, revealed that the facility provided an In-Service Education about signing out narcotics and accounting of narcotics between incoming and outgoing shifts.

A review of the Facility's Policy titled "Controlled Drug Count Record (CDCR) and Controlled Drug Index (CDI)" dated 8/1/10, revealed that at the change of shift and/or at any time in which the narcotic keys are surrendered to another responsible party, the outgoing responsible party should count all controlled drugs with the incoming responsible party. The Policy indicated that both responsible parties would count the number of bingo cards, packs/boxes, and bottles, and document the count on the designated spaces. It also indicated that all discontinued controlled drugs would be included in the count until surrendered to the Supervisor for destruction. The same Policy revealed that at the

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end of each month, a reconciliation of all drugs in the medication cart will be completed and a new CDCR and CDI form would be initiated.

A review the facility's Policy titled "Disposal of Non Hazardous Medications-Controlled Medications" revised on 6/4/14, revealed that it is the policy of the facility to assure that discontinued medications were removed from the active medication supply in a timely fashion, were returned to the provider if allowed by law and policy, were disposed of in compliance with laws and standards, and were accounted for and documented completely and accurately. The policy revealed that the controlled medications would remain in the medication cart under double lock until removed by the DON or designee for appropriate storage or immediate destruction. This Policy indicated that destruction of controlled substances would be completed by two individuals and in accordance with state, federal, and local regulations. It also revealed that both the destroying professional and the witnessing professional should sign the completion/witnessing of the destruction on the declining inventory.

A review of the undated facility's Policy titled " Medication orders and Receipt Record" revealed that the Director of Nursing Services would designate individuals to be responsible for completing medication order/receipt forms and medications should be ordered in advance, based on the dispensing pharmacy's required lead time.

A review of the undated facility's Policy titled "Documentation on Medication Administration Record" revealed that the facility should maintain the medication administration record to document

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F 431	Continued From page 33 all medications administered. The policy explained that the Nurse should document all medications administered to each resident's Medication Administration Record (MAR). It also explained that the documentation must include, as a minimum: (f.) signature and title of the person administering the medication. NJ 8:39-29.2(a) NJ 8:39-29.2(d) NJ 8:39-29.4(g) NJ 8:39-29.4(i) NJ 8:39-29.4(k)	F 431		
F 492 SS=E	483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD (b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. (c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45	F 492		2/16/17

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F 492	Continued From page 34 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: C# NJ 95717, C# NJ 95718 Cross Reference F-281 Based on observation, interviews, medical record (MR) review, and review of other facility documentation on 1/20/17, it was determined that the facility failed to follow the facility's policy on controlled substances by borrowing Schedule II controlled medications (Dilaudid) and Schedule IV medications (Xanax) for 3 of 9 sampled residents (Resident #1, #2 and #3) and administering these controlled medications to 4 of 9 sampled residents (Resident #5, #6, #7 and #8). This deficient practice was evidenced by the following. See example #1, #2, #3, #4, #5, #6, #7 NJ 8:39-29.2(a) NJ 8:39-29.2(d)	F 492	1.Residents noted in survey sample have been discharged from COAW. 2.All Residents have the potential to be affected. Residents found in need of Schedule 1-5 control prescription or refill will be obtained by Physician to be. sent to the Pharmacy to fill. Control Accountability Declining Records for current residents audited for evidence of borrowing. 3.Facility educator/ designee will inservice licensed nurses that the facility has a no borrowing policy and the process for Medication Availability. Unit Manager or designee will audit current residents with an order for Schedule 2 (Dilauded) and Schedule 4 (Xanax) to ensure Individual Resident Prescription availability to dispense as prescribed in accordance with the Physician Orders.	

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F 492	Continued From page 35	F 492	Director of Nursing obtained DEA 222 forms for Pyxis control ordering inventory process in conjunction with Medical Director to supply Pyxis with schedule 1-5. 4.DON/ UM/ Designees will conduct audits of Control Accountability Drug Records for 2 residents weekly for 3 months to confirm no borrowing of medication.. FE/ ADON or designee will conduct medication pass competency for 2 nurses monthly for 3 months for evidence of proper technique for medication administration inclusive of controlled medication administration to verify no borrowing in practice. Findings will be presented at the Quality Assurance monthly meeting and further recommendations by committee will be made as needed.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315477	A. Building B. Wing	4/4/2017

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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0281 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 02/16/2017	ID Prefix F0431 Reg. # 483.45(b)(2)(3)(g)(h) LSC	Correction Completed 02/16/2017	ID Prefix F0492 Reg. # 483.70(b)(c) LSC	Correction Completed 02/16/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/20/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO