

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2024
NAME OF PROVIDER OR SUPPLIER  Cedar Crest Nursing Centre Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  125 Scituate Avenue Cranston, RI 02920	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>39496</p> <p>Based on record review and staff interview, it has been determined that the facility failed to store drugs and biological's in accordance with currently accepted professional principles for 1 of 1 medication cart reviewed.</p> <p>Findings are as follows:</p> <p>Record review of a facility reported incident submitted to the Rhode Island Department of Health on 7/19/2024 revealed that Resident ID #1 was unable to receive his/her 10:00 PM dose of Lyrica (a controlled medication used to treat pain) 25 milligrams (mg) on July 18, 2024, because the facility was unable to locate the 16 pills that were documented as available in the narcotic book.</p> <p>Record review of a facility policy titled, Controlled Medication storage revealed in part, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the nursing care center in accordance with federal, state, and other applicable laws and regulations .Only authorized licensed nursing and pharmacy personnel have access to controlled medication. The medication nurse on duty maintains possession of the key to controlled medication storage areas .At each shift change or when keys are surrendered, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report. The nursing care center may elect to count all controlled medications at shift change.</p> <p>Record review revealed Resident ID #1 was admitted to the facility in August of 2023, with diagnoses including, but not limited to, rheumatoid arthritis severe with contractures (permanent shortening and tightening of muscle fibers), age related osteoporosis (condition that weakens bones) without current pathological fracture, wedge compression fracture (occurs when one side of a vertebra collapses, creating a wedge shape) of T11-T12 vertebra, and wedge compression fracture of second lumbar vertebra.</p> <p>Record review revealed a physician's order for Lyrica 25 mg three times daily at 6:00 AM, 2:00 PM, and 10:00 PM, for pain management.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the narcotic book for Resident ID #1 revealed that after his/her 2:00 PM dose was administered on 7/18/2024 s/he had 16 Lyrica 25 mg pills remaining. Writing on the bottom of the narcotic book page, written by the Director of Nursing Services (DNS) stated 7/18/24 removed from count.</p> <p>During a surveyor interview on 8/5/2024 at 12:48 PM with Licensed Practical Nurse, Staff A, she revealed that she gave the resident the scheduled Lyrica at 2:00 PM. She further revealed that at change of shift she completed the narcotic count with the oncoming shift nurse. She revealed that during count she read the resident names and the number of pills they should have, and the oncoming nurse checked the pill card to ensure the number of pills matched. She said at no time during the count was she notified of a missing card. She stated after the count was completed, she signed the narcotic book, gave the oncoming nurse the keys to the medication cart, and left for the day.</p> <p>During a surveyor interview on 8/5/2024 at approximately 2:30 PM with Licensed Practical Nurse, Staff B, she revealed that during the narcotic count at change of shift, the day nurse never said Resident ID #1's name and so the Lyrica was not counted. Additionally, she stated she didn't realize that the resident's Lyrica was missing until later in the shift.</p> <p>During a surveyor interview on 8/5/2024 at 2:22 PM, with the DNS, she revealed that the Lyrica may have been thrown away by accident. She states that she documented 7/18/24 removed from count in the narcotic book, because the 16 pills were not found. Additionally, she was unable to provide evidence that the Lyrica was stored in accordance with currently accepted professional principles.</p> <p>Upon further interview with the DNS, she indicated that after the above incident the following interventions were put into place at the facility:</p> <ul style="list-style-type: none"> <li>a) Both nurses that were involved in the narcotic count on 7/18/2024 were provided one on one education regarding the narcotic count procedure.</li> <li>b) An in-service was held for all nurses to educate them on the proper narcotic count procedures.</li> <li>c) Audits were conducted, and will continue to be conducted for 3 months, of the narcotic count procedure.</li> <li>d) Results of the audits will be discussed at Quality Assurance Performance Improvement meetings.</li> </ul>		