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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>676315 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>08/03/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Hillcrest of North Dallas |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>18648 Hillcrest Rd<br>Dallas, TX 75252 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
|---|---|
| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405</b></p> <p>Based on observation, interviews, and record review, the facility failed to 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 for 1 (Resident #1) of 2 residents reviewed for pharmacy services.</p> <p>On 08/02/24, LVN A failed to complete documentation on Resident #1's controlled medication count sheet after 2 Acetaminophen - Codeine 300 - 30 mg [Generic for Tylenol with Codeine #3] oral tablets ([white, round tablet] a controlled combination medication used to relieve moderate to severe pain) were removed from the medication blister pack for administration.</p> <p>As of 08/02/24, the facility failed to remove Resident #2's controlled medications from the Hall 400 medication cart after [Resident #2] discharged from the facility on 07/17/24.</p> <p>On 08/02/24, LVN A removed 2 white, round tablets from Resident #2's (discharged from facility on 07/17/24) medication blister pack ([Fioricet 50-325-40 mg] a combination drug for the relief of the symptom complex of tension, or muscle contraction headache) for administration to Resident #1 when a PRN pain medication was requested. Resident #1 refused to take the medication.</p> <p>LVN A, LVN C, LVN D, and LVN E failed to document the administration and/or refusal of a controlled medication (Acetaminophen - Codeine 300 - 30 mg oral tablets) in a correct and timely manner on Resident #1's MAR.</p> <p>These failures could place residents at risk for medication errors, ineffective relief from pain medication, and drug diversion of controlled substances.</p> <p>Findings included:</p> <p>Review of Resident #1's comprehensive (Significant change in status) MDS assessment, dated 05/23/24, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had a history and diagnoses of A-fib, DVT, Unspecified Diastolic CHF; Unspecified Urinary Incontinence; and DM. Resident #1 had intact cognition with a BIMS score of 13.</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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| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                   | Event ID:<br><br>Facility ID:<br>676315 | If continuation sheet<br>Page 1 of 7 |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Record review of a re-entry MDS assessment, dated 06/18/24, reflected Resident #1 readmitted to the facility on [DATE] from a short-term general hospital. Resident #1 was under the care of hospice services (Admit: 06/21/24) and received pain medication as needed.</p> <p>Review of Resident #1's active physician's orders dated, 08/01/2024, reflected Tylenol with Codeine #3 Oral Tablet 300-30 MG (Acetaminophen w/ Codeine). Give 2 tablets by mouth every 6 hours as needed for Pain. (Order date 06/21/24; Start date 06/21/24).</p> <p>Record review of Resident #1's care plan, last review date 04/30/24, reflected [Resident #1] was at risk for generalized pain r/t COPD, arthritis, and weakness (Initiated: 05/17/24). Interventions included pain medication administration; anticipate pain and respond immediately; monitor and document cause of pain and side effects; and evaluate effectiveness of pain interventions. The goal was for [Resident #1] to verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date (Initiated: 05/17/24; Revised: 06/11/24; Target date: 09/09/24).</p> <p>Record Review revealed a Change of Shift Controlled Medication Count Sheet for August 2024 that revealed the oncoming nurse (LVN A [2P - 10P]) and off going nurse (LVN G [6A - 2P]) signatures on 08/02/2024. Their signatures verified all controlled medications were counted and the count was correct. Resident #1's controlled medications and count sheets were separated in a miscellaneous secondary locked compartment. Resident #1's count sheets were not included in the Controlled Medications Binder.</p> <p>The facility did not provide copies of Resident #1's previous controlled medication count sheets (prior to 07/30/24) for Acetaminophen - Codeine 300 - 30 mg oral tablets upon request on 08/02/24 at 7:00 PM or on 08/03/24 prior to exit conference.</p> <p>Record review of the Resident #2 closed chart revealed [Resident #2] discharged from the facility on 07/16/24. The resident's controlled medications remained on the 400 Hall medication cart.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During an observation and interview on 08/02/24 at 4:07 PM, Resident #1 was sitting upright in bed. Resident #1's physical appearance presented without visible injuries or behavior suggesting abuse, neglect, or subquality care. Resident #1 was alert and oriented x 4 (self, place, time, situation). Resident #1 spoke loudly, forcefully, and with good articulation. Resident #1 often interrupted and urged to state her viewpoint during the interview. Resident #1 stated that the facility was not giving her the correct pain medication. Resident #1 said that when she received pain medication, she was administered 2 pills that make her feel loopy and was sure that she was administered the wrong medication. Resident #1 reached into the top drawer of the nightstand and pulled out a glucose monitor organizer case. Resident #1 unzipped the case and reached in an internal pocket and pulled out 1 white, round tablet (imprint: W 242 on one side, blank on the other side [Acetaminophen - Codeine 300 - 30 mg oral tablets]). Resident #1 indicated the facility administered 2 [white, round] tablets identified with the W 242 instead of Tylenol with Codeine #3 and placed the pill on the bedside table. Resident #1 removed a black glucose test strip container from the case, opened the container, and removed a white, round tablet (imprint: M on one side, 3 on the other side [Acetaminophen - Codeine 300 - 30 mg oral tablets]). Resident #1 said the pill came from home and described the pill as a textured feel, with a #3 imprint. Resident #1 stated, this is Tylenol with Codeine #3 . they [facility staff] are not giving me the right medication and returned the pill to the container, zipped the case shut, and placed the case in the nightstand drawer. Resident #1 indicated she voiced her concerns with the nursing staff and a female nurse (could not recall name or the date) showed [Resident #1] the medication blister pack filled that the nurse retrieved the medication. Resident #1 said that the medication blister pack said Acetaminophen - Codeine 300 - 30 mg oral tablets but that is not Tylenol with Codeine #3. Resident #1 said that she took the medication and demanded that the nurse call the doctor and tell him to prescribe Tylenol #3 with Codeine. At 5:05 PM, Resident #1 pressed the call light to request pain medication. CNA B acknowledged Resident #1's request for pain medication and indicated she would notify the nurse. At approximately 5:30 PM, LVN A entered the room and handed Resident #1 a medication cup with 2 round, white pills. LVN A did not inquire about Resident #1's pain level or inform what pills were given to Resident #1. Resident #1 inspected the pills in the cup and compared the pills to the pill on the bedside table. Resident #1 indicated that the pills were not Tylenol #3. Resident #1 refused to take the pills, sat the medication cup on the bedside table, and placed the pill she removed from the glucose monitor organizer case earlier into the cup. LVN A acknowledged understanding and retrieved the medication cup from the bedside table. The investigator accompanied LVN A out of the room to observe the procedure to discard controlled medications when a resident refused.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During an interview, observation, and record review on 08/02/24 at 6:21 PM, LVN A retrieved a medication blister pack from a miscellaneous locked compartment (separate from the locked compartment that contained all other controlled medications) within the Hall 400 medication cart. Observation of the medication label affixed to the medication blister pack, received from the pharmacy on 07/28/24, reflected Resident #1's name, Acetaminophen - Codeine Oral Tablet 300-30 MG. White, round tablet. Generic for Tylenol with Codeine #3. Give 1 tablet by mouth every 6 hours as needed for Pain. There were 23 tablets remaining. Record review of Resident #1's MAR reflected the last dose was administered on 07/30/24 at 4:00 AM. LVN A could not locate the controlled medication count sheet for record review and stated he did not document when he removed the 2 tablets. During an interview, LVN A stated that he was unaware the Resident #1 had medications stored in the room. LVN A said that he needed to discard the pills with another nurse and document on the MAR that [Resident #1] refused. LVN A indicated that controlled medications were counted at the beginning and at the end of shift. LVN A said that controlled medications must be secured in a locked compartment within the locked medication cart and documented on a count sheet whenever removed from the medication blister pack. LVN A said that Resident #1's controlled medications were counted with the other controlled medications at shift change, although the narcotic sheet was not with the other count sheets in the Controlled Medication Binder. LVN A said the risk of not documenting controlled medications on the count sheet when removed was an inaccurate count.</p> <p>During an interview, observation, and record review on 08/02/24 at 6:26 PM, the DON informed LVN A to notify the doctor [Acetaminophen - Codeine Oral Tablet 300-30 MG] was offered to Resident #1 as requested for pain, but [Resident #1] refused; and a pill was found. The DON assisted LVN A to locate Resident #1's [Acetaminophen - Codeine Oral Tablet 300-30 MG] count sheet to witness the disposal of the controlled medications. The DON pulled a blank controlled medication count sheet from the Controlled Medications Binder, wrote Resident #1's name and Tylenol #3 on the top of the form; then, entered the current date and time (08/02/24, 4:00 PM) on the first line (#1). In the second column, on line 25, the DON wrote the date [08/02/24], dose [300-30 mg], amount [2], amount wasted (destroyed) [2 + 1], administered by [LVN A], and amount remaining [23]. LVN A and the DON signed as the witnesses on the controlled medication count sheet. During an interview, the DON said that he did not know where the pill(s) came from that were in Resident #1's possession. The DON said the controlled medication count sheet he created did not display all the entries but would capture the moment. The DON indicated the nurse must document on the count sheet once the controlled pill was removed from the medication blister pack and prior to administering to a resident. The DON said that the nurse must check the count to ensure accuracy. Then, the nurse must initial the MAR after administering the medication. The DON said that the nurse must ensure that all PRN documentation is completed on the MAR and in the nursing notes after administration of PRN controlled medications. The DON said that his expectation and the facility policy was for staff to immediately count the remaining pills and document the removal of controlled meds and remaining number of pills on the appropriate count sheet; then, document on the MAR when the medication was administered. The DON said if a resident refused a medication, the nurse must document refused on the MAR and appropriately dispose of the controlled medication . another nurse must witness and both nurses must sign the count sheet the medications were disposed.</p> <p>During an observation on 08/02/24 at 6:30 PM revealed the disposal method of the three pills into an authorized collection receptacle with LVN A and the DON. Both nurses signed the handwritten controlled medication count sheet, entered the date, time, amount destroyed, and amount (23 pills) remained.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On 08/03/24 at 8:30 AM an outbound call was placed to LVN C. The call was answered by a recorded message that indicated the subscriber requested not to accept incoming calls and the call ended.</p> <p>During a phone interview on 08/03/24 at 08:40 AM, LVN D indicated she worked PRN on Hall 400. LVN D said that she last worked at the facility on 07/30/24 and 07/31/24. LVN D stated she recalled Resident #1 and that she administered Acetaminophen - Codeine Oral Tablet 300-30 MG, 2 tablets, as reflected on the MAR, 07/30/24 at 4:00 AM and 07/31/24 at 5:50 AM. LVN D said when a resident requested a PRN (controlled) medication, she reviewed the MAR to indicate the last time received, how often the pill could be given, and to make sure it was not too soon to give. LVN D said that she would also verify the last time the medication was given on the controlled medication count sheet. LVN D said she would review the order and the medication blister pack to ensure she was giving the right medication, right dose, to the right resident, at the right time. LVN D stated on 07/31/24, Resident #1 said that the medication she received was not Tylenol #3. LVN D said that she retrieved the Acetaminophen - Codeine Oral Tablet 300-30 MG blister pack from the medication cart to show Resident #1 that [LVN D] administered the correct medication. LVN D said that Resident #1 told her to call the doctor and tell him she wanted Tylenol #3. LVN D said that after she administered the PRN medication, she initialed the MAR. LVN D said that she must have forgot or got distracted and that was why her initial was not reflected on the MAR on 07/31/24. LVN D said that all controlled medications must remain together in the primary locked compartment in the locked medication cart; and all count sheets remained in the Controlled Medication Binder. LVN D said if a medication was discontinued, or the resident discharged from the facility the ADON or DON was notified that controlled medications needed to be removed from the medication cart. The controlled medications were counted and verified by a second nurse (who will co-sign), the count sheet was removed from the binder and wrapped around the medication blister card, removed from the primary locked compartment, and placed in the miscellaneous locked compartment within the medication cart for the ADON or DON to remove for destruction.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During an interview and record review on 08/03/24 at 2:29 PM, the DON presented a controlled medication count sheet with a duplicate label attached that reflected Resident #1's Acetaminophen - Codeine Oral Tablet 300-30 MG. The label on the count sheet matched the information on the medication label affixed to the medication blister pack. The count sheet reflected 2 tablets were administered on 07/30/24 at 4:00 AM by LVN D, 07/31/24 at 5:50 AM by LVN D, 07/31/24 at unknown time by unknown signature, and 1 tablet removed for administration on 08/01/24 at 1:39 AM by LVN C. The remaining count reflected 23 pills. Two nurse signatures were signed next to the amount remained (on 08/01/24). Record review of Resident #1's July and August 2024 MAR's reflected Tylenol with Codeine #3 Oral Tablet 300-30 MG (Acetaminophen w/ Codeine). Give 2 tablets by mouth every 6 hours as needed for Pain. (Order date 06/21/24). The MAR did not reveal initials on 07/31/24 (at 5:50 AM or unknown time signed out on count sheet), 08/01/24, or 08/02/24 that indicated the medication was administered or refused on those days. The DON said that he initiated an investigation and discovered LVN A removed the 2 pills from another resident's medication blister pack. The DON said that he discovered the discrepancy in which the quantity of drug present was not the quantity expected. The DON said that he corrected the count sheet to reflect the new total. The DON presented a copy of Resident #2's count sheet that reflected the drug name Fioricet (combination drug for the relief of the symptom complex of tension (or muscle contraction) headache) 50-325-40 mg, the Resident #2 name, date received 06/18/24, amount received 30, and a signature. The count sheet revealed 3 entries that indicated 1 tablet was administered each time and 27 pills remained. The last entry was 07/16/24 at 5:00 PM. Below the last entry revealed two nurse signatures that verified 27 pills remained. The order was discontinued on 07/17/24. Another entry, dated 08/02/24, reflected, Corrected Count (25) 2 tablets erroneously popped out - (Destroyed) and the DON and LVN A's signatures were written beside the statement. The DON said that the nurse must review the Medication Rights (Right person, Right medication, Right dose, Right form, Right route, and Right time) before a medication is administered to a resident. The DON said the risk could be an allergic reaction, administered to the wrong resident, administered too soon or too late. The DON stated LVN A was immediately suspended and sent home pending investigation. Record review of the Corrective Action Memo, dated 08/02/24, reflected LVN A failed to follow protocol on admission audit and completion. Entered several orders incorrectly and missed many others. Failed to complete SBAR on [patient A.P.] to her toe . Action being taken: Suspension Termination . Objectives/Solution: Suspension pending investigation. The DON and LVN A signed the document. The DON indicated he conducted cart audits on all 4 medication carts to rule out any narcotic concerns and no issues were found. The DON stated the investigation findings indicated LVN A did not pull medications from the right medication cart and did not follow the 5 rights of medication administration. The investigation findings resulted in the decision to terminate [LVN A's] employment.</p> <p>Record review of an Education/Training Record dated 08/02/24, presented by the DON as a one-on-one in-service with LVN A topics included: 5 Rights of Medication Administration, Signing the narcotic sheet after pulling out medication, Assessing pain before administering pain medication, Med destruction, Notifying MD, and Removing DC'd meds from cart. LVN A's signature appeared on the sign in sheet.</p> <p>Record review of an Education/Training Record dated 08/02/24, presented by the DON topics included: 5 Rights of Medication Administration, Signing the narcotic sheet after pulling out medication, Assessing pain before administering pain medication, Med destruction, Notifying MD, Removing DC'd meds from cart, and Making sure patient swallows pill before leaving. The sign in sheet reflected LVN H (2P - 10P), LVN (6A - 2P), MA I (6A - 10P Weekend), LVN E (6A - 10P Weekend), LVN J (6A - 10P Weekend), and LVN K (6A - 10P Weekend). The in-service was on-going.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of the facility's policy Discrepancies, Loss, and/or Diversion of Medications, revised 08/2020 reflected the following:</p> <p>Policy</p> <p>All discrepancies, suspected loss, and/or diversion of medications, irrespective of drug type or class, are immediately investigated .</p> <p>Procedures</p> <p>Immediately upon discovery or suspicion of a discrepancy, suspected loss of diversion, the Administrator, DON, and consultant pharmacist are notified, and an investigation conducted. The DON leads the investigation.</p> <p>I. Discrepancy in a Drug count</p> <p>1. The DON investigates the discrepancy and researches all the records related to medication administration and the supply of the medication, including medication reconciliation.</p> <p>2. If the discrepancy cannot be reconciled after a thorough investigation has been completed, the remaining supply is documented with the current date and time and the accountability process restarted at this point. The discrepancy is document unable to reconcile.</p> <p>4. Any corrective action that the DON deems appropriate should be taken.</p> <p>Review of the facility's policy Administration Procedures for All Medications, revised 08/2020 reflected the following:</p> <p>Policy</p> <p>Medications will be administered in a safe and effective manner.</p> <p>III. 5 Rights (at a minimum)</p> <p>At a minimum, review the 5 rights at each of the following steps of medication administration.</p> <p>1. Prior to removing the medication package/container from the cart/drawer: a. Check the MAR for the order.</p> <p>2. Prior to removing the medication from the container: a. Check the label against the order on the MAR.</p> <p>IV. Administration</p> <p>9. If a resident refuses medication, document refusal on the MAR.</p> |   |  |