

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155838	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2015
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NAME OF PROVIDER OR SUPPLIER STONECROFT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00187607 and IN00189292.</p> <p>Complaint IN00187607 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309.</p> <p>Complaint IN00189292 - Substantiated. Federal/State deficiencies related to the allegations are cited at F278.</p> <p>Survey dates: December 21 & 22, 2015</p> <p>Facility number : 013409 Provider number: 155838 AIM number: 201312610</p> <p>Census bed type: SNF/NF: 30 Residential: 23 Total: 53</p> <p>Census payor type: Medicare: 12 Medicaid: 9 Other : 32 Total: 53</p> <p>Sample: 5</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 0278 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on December 30, 2015.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil</p>			

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	<p>money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the accuracy of the annual Minimum Data Set (MDS) assessment for 2 of 5 residents reviewed for accuracy of their MDS. (Resident #A, Resident #D)</p> <p>Findings include:</p> <p>On 12/21/15 at 2:19 p.m., an interview with Resident #A's daughter indicated, Resident #A had open area underneath her eye on admission.</p> <p>Resident #A's clinical record was reviewed on 12/21/15 at 11:30 a.m. Diagnoses included, but were not limited to: skull fracture, maxillary fracture and history of falls.</p> <p>Discharge instructions from a local hospital dated 11/11/15, indicated, "...Keep incision dry until 4 days after staples are taken out. ..." The discharge instruction did not indicate where the incision nor staples were located.</p> <p>Physician's orders dated 11/11/15, indicated to keep incision dry until 4 days after staple removed. Resident #A's</p>	F 0278	<p>F 278</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>Resident #A has been discharged. The MDS of Resident #D will be modified to reflect the accuracy of the staging of the documented wound.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>The MDS Coordinator will review the most recent MDS of residents with wounds to ensure the accuracy.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p>	01/21/2016

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	<p>clinical record lacked documentation of having staples, nor of an incision. There was no documentation indicating any skin treatment being provided to Resident #A.</p> <p>Admission assessment dated 11/11/15, indicated Resident #A had skin impairment and to complete the appropriate wound circumstance assessment form. The clinical record lacked documentation of a wound circumstance assessment being completed.</p> <p>Admission skin assessment progress note dated 11/11/15, indicated the following:</p> <p>abrasions to right outer forearm abrasions to left elbow elevated bump to left temple bruise to left outer thigh bruise covering left temple, left cheek, left side of neck, left jawbone, and upper chest. bruise covering right breast bruising under both eyes multiple scattered bruising on bilateral upper extremities 2 pinpoint scabs on right anterior shin The Admission Minimum Data Set (MDS) assessment dated 11/18/15, indicated Resident #A had surgical wounds and required surgical wound</p>		<p>MDS Support will re-educate the MDS Coordinator on completion of the MDS with accuracy related to wound staging.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>The following audits and /or observations for 3 residents will be conducted by the MDS Coordinator or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>care. The MDS lacked documentation of where the surgical wound was located on Resident #A.</p> <p>Treatment Administration History documentation dated 11/12/15 through 11/24/15, indicated no skin impairments were identified on the weekly skin assessment.</p> <p>On 12/22/15 at 1:49 p.m., a phone interview with the admission's Licensed Practical Nurse (LPN) #1 indicated, Resident #A had an incision on the back of her head, not sure if the incision had staples. "We didn't provide any treatment. We just monitored."</p> <p>On 12/22/15 at 12:01 p.m., a phone interview with Licensed Practical Nurse (LPN) #2 indicated, Resident #A had staples in the back of her head and believes Resident #A was discharged home with the staples remaining.</p> <p>Resident #A's admission MDS dated 11/18/15, indicated Resident #A had surgical wounds and required surgical wound care.</p> <p>On 12/22/15 at 3:00 p.m., an interview with the MDS Coordinator, indicated no physical assessment was completed for Resident #A. The information provided</p>			

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	<p>on the MDS was taken from the local hospital discharge orders and from speaking with the staff about Resident #A. "Resident #A did not have staples nor a surgical site on admission. There were lots of bruises. I hadn't had a chance to look at the resident. I just went by the discharge instructions about the surgical incision."</p> <p>2). Resident #D's clinical record was reviewed on 12/21/15 at 12:00 p.m. Diagnoses included, but were not limited to: cerebral infarction, hypertension and depressive episodes.</p> <p>Pressure ulcer assessment form dated 11/17/15, indicated Resident #D had a stage 2 pressure area to the right buttock.</p> <p>The Admissions Minimum Data Set (MDS) assessment dated 11/27/15, indicated Resident #D had an unhealed stage 1 pressure ulcer.</p> <p>On 12/22/15 at 3:00 p.m., an interview with the Minimum Data Set (MDS) Coordinator, indicated, "Resident #D had a stage 2 pressure ulcer prior to admission at the previous nursing facility. The MDS Coordinator indicated after she observed the pressure area on Resident #D the stage was 1. The wound progress notes dated 12/2/15, indicated Resident</p>			

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F 0309 SS=E Bldg. 00	<p>#D had a moisture associated open area to gluteal cleft. "I know, you can't down stage a pressure ulcer. I will have to re-educate [wound nurse]."</p> <p>This Federal tag is related to Complaint IN00189292.</p> <p>3.1-31(i)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure residents prescribed medications were available to be administered as ordered by the physician for 4 of 5 residents reviewed for medication administration. (Resident #A, Resident #B, Resident #D, Resident #E)</p> <p>Findings include:</p> <p>1).On 12/21/15 at 2:19 p.m., interview</p>	F 0309	<p>F 309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>Resident A has been discharged from the campus.</p> <p>Resident B, D, and E medications</p>	01/21/2016

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	<p>with Resident #A's daughter indicated, on 11/23/15, staff nurse had come into Resident #A's room around 6:30 p.m., to give evening medications. "I questioned the nurse (LPN #1) about mother's sleeping pill and was told they didn't have the medication in the building. They would have to call the local pharmacy to get the sleeping pill. "They woke my mother up at 3:00 [a.m.] to give the sleeping pill."</p> <p>Resident #A's clinical record was reviewed on 12/21/15 at 11:30 a.m. Diagnoses included, but were not limited to: skull fracture, maxillary fracture and history of falls.</p> <p>Discharge orders from a local hospital dated 11/11/15, indicated, "TEMazePAM ...30 mg [milligram] At bed time By mouth. ..."</p> <p>Physician's orders dated 11/11/15, indicated, "temazepam ...30 mg ... 1 capsules ; oral At Bedtime; 7:00 p.m., - 10:00 p.m. ...Lantus ...10 units ...At Bedtime; 8:00 p.m. -11:30 p.m. ..."</p> <p>The Medication Administration History indicated on the following dates medications were not available as ordered to administer to Resident #A:</p>		<p>were reviewed and have had no further incidents of missed doses of medication.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>Residents receiving medications have the potential to be affected.</p> <p>When a medication is noted to be unavailable the DHS or designee will be notified by staff to ensure proper actions to obtain the medication.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Medication Pass Procedure and Error Prevention Policy, ordering and receiving of medication, Late Administration, EDK, Back Up pharmacy if meds are unavailable and associated documentation.</p>	

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	<p>On 11/12/15, for 7:00 p.m.- 10:00 p.m., medication administration temazepam (hypnotic) 30 mg was not administered.</p> <p>On 11/19/15, for 8:00 p.m.- 11:30 p.m., medication administration Lantus 10 units was not administered.</p> <p>On 11/23/15, for 7:00 p.m.- 10:00 p.m., medication administration temazepam 30 mg was not administered.</p> <p>The clinical records lacked documentation indicating the missed medications were given at a later time.</p> <p>Delivery Sheet from the back up pharmacy dated 11/11/15, lacked documentation of temazepam nor Lantus being delivered.</p> <p>Nurses progress notes dated 11/11/15, indicated "Faxed script received from local hospital, and faxed to backup pharmacy requesting evening meds [medication] to be sent from backup pharmacy."</p> <p>The emergency drug kit (EDK) usage report dated 11/20/15, indicated a NovoLog vial was removed for Resident #A. The log lacked documentation of Lantus being removed from the EDK.</p>		<p>The IDT will review the missed medication report daily x 5 days a week to ensure compliance.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>The DHS/Designee will audit the MARs of 3 residents 2 x week times 8 weeks, then monthly times 4 months to ensure compliance:</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>On 12/22/15 at 9:02 a.m., the Director of Nursing (DON) indicated, medications on the skilled nursing unit are reordered electronically by pushing a button on the computer under the resident's profile.</p> <p>On 12/22/15 at 11:49 a.m., an interview with Licensed Practical Nurse (LPN) #1 indicated, when ordered medication is not available, she would notify the physician, pharmacy, and patient's family. "We would take the medication out of the emergency drug kit (EDK) if available. If not we call the backup pharmacy. The medication should be reordered when down to a couple of pills." LPN #1 indicated all nurses are responsible to reorder medication. The medication card has a notice saying to reorder now. LPN #1 indicated facility protocol was to document medication not given and unavailable.</p> <p>On 12/22/15 at 12:01 p.m., an interview with Licensed Practical Nurse (LPN) #2 indicated, if resident's order medication was not available I would check the emergency drug kit (EDK). If not available I would get it (medication) from the pharmacy. I personally call the and ask why the medication was not here. If I can't get it immediately, I would document at that time and the resident would go without. "If I don't have it, I</p>			

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	<p>don't have it." LPN #2 indicated, all nurses are responsible for reordering medications. "We can order stat [immediately]." LPN #2 indicated if the medication was given later it should be documented. The clinical record lacked documentation of omitted medication being administered at a later time.</p> <p>On 12/22/15 at 12:40 p.m., the Director of Nursing (DON) indicated when medication was not available for a resident the nurses check the emergency drug kit (EDK) and if not available call the pharmacy. "They wait for the medication to come from backup." The DON indicated the local hospital was not sending the resident's hard copy prescription.</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, indicated, "... temazepam ...Nursing considerations: ... Don't stop drug abruptly as this may cause withdrawal symptoms...To discontinue drug, follow a gradual dosage-tapering schedule. ...Warn patient not to stop drug abruptly if taken for 1 month or longer. ..."</p> <p>2). Resident #B's clinical record was reviewed on 12/21/15 at 10:50 a.m. Diagnoses include, but were not limited to: rheumatoid arthritis and neuropathy.</p>			

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	<p>Physician's order dated 11/04/15 through 12/22/15, indicated "Norco 10/325 mg (pain medication) give at bedtime 7:00 p.m., -11:30 p.m. Norco 10/325 mg give 4 times as day as needed. Calcium 600 mg plus vitamin d3 give three times a day 4:00 a.m.-10:00 a.m., 11:00 a.m.-1:30 p.m., 6:00 p.m. -10:00 p.m."</p> <p>The Medication Administration History indicated on the following dates medications were not available as ordered to administer to Resident #B</p> <p>On 12/19/15, 7:00 p.m.- 11:30 p.m., medication administration Norco 10/325 mg was not administered.</p> <p>On 12/5/15, 11:00 a.m.- 11:30 p.m. nor 6:00 p.m. -10:00 p.m., medication administration calcium with vitamin D3 was not administered.</p> <p>The clinical records lacked documentation indicating the missed medications were given at a later time.</p> <p>On 12/22/15 at 9:02 a.m., the Director of Nursing (DON) indicated, medications on the skilled nursing unit are reordered electronically by pushing a button on the computer under the resident's profile.</p>			

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	<p>On 12/22/15 at 11:49 a.m., an interview with Licensed Practical Nurse (LPN) #1 indicated, when ordered medication is not available, she would notify the physician, pharmacy, and patient's family. "We would take the medication out of the emergency drug kit (EDK) if available. If not we call the backup pharmacy. The medication should be reordered when down to a couple of pills." LPN #1 indicated all nurses are responsible to reorder medication. The medication card has a notice saying to reorder now. LPN #1 indicated would document medication not given and unavailable.</p> <p>On 12/22/15 at 12:01 p.m., an interview with Licensed Practical Nurse (LPN) #2 indicated, if resident's order medication was not available I would check the emergency drug kit (EDK). If not available I would get it (medication) from the pharmacy. I personally call the and ask why the medication was not here. If I can't get it immediately, I would document at that time and the resident would go without. "If I don't have it, I don't have it." LPN #2 indicated, all nurses are responsible for reordering medications. "We can order stat [immediately]." LPN #2 indicated if the medication was given later it should be documented. The clinical record lacked documentation of omitted medication</p>				

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	<p>being administered at a later time.</p> <p>On 12/22/15 at 12:40 p.m., the Director of Nursing (DON) indicated when medication was not available for a resident the nurses check the emergency drug kit (EDK) and if not available call the pharmacy. "They wait for the medication to come from backup." The DON indicated the local hospital was not sending the resident's hard copy prescription.</p> <p>Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, indicated, "... Norco ...Patient Teaching For best results, instruct patient to take drug before pain becomes severe."</p> <p>3). Resident #D's clinical record was reviewed on 12/21/15 at 11:20 a.m. Diagnoses included, but were not limited to: cerebral infarction, hypertension, ischemic cardiomyopathy and depressive episodes</p> <p>Physician's orders dated 11/20/15 through 12/22/15, indicated, Xarelto (use to prevent stroke)15 mg (milligram) a day, and amiodarone 200 mg every 8 hours.</p> <p>The Medication Administration History indicated on the following dates medications were not available as</p>			

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NAME OF PROVIDER OR SUPPLIER STONECROFT HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403		
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	<p>ordered to administer to Resident #D:</p> <p>On 12/14/15, for 12:00 a.m., medication administration amiodarone 200 mg were not administered.</p> <p>On 12/8/15 and 12/9/15, Xarelto 15 mg (used to reduce the risk of stroke) were not administered.</p> <p>The clinical records lacked documentation indicating the missed medications were given at a later time.</p> <p>On 12/22/15 at 9:02 a.m., the Director of Nursing (DON) indicated, medications on the skilled nursing unit are reordered electronically by pushing a button on the computer under the resident's profile.</p> <p>On 12/22/15 at 11:49 a.m., an interview with Licensed Practical Nurse (LPN) #1 indicated, when ordered medication is not available, she would notify the physician, pharmacy, and patient's family. "We would take the medication out of the emergency drug kit (EDK) if available. If not we call the backup pharmacy. The medication should be reordered when down to a couple of pills." LPN #1 indicated all nurses are responsible to reorder medication. The medication card has a notice saying to reorder now. LPN #1 indicated would document medication</p>				

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	<p>not given and unavailable.</p> <p>On 12/22/15 at 12:01 p.m., an interview with Licensed Practical Nurse (LPN) #2 indicated, if resident's order medication was not available I would check the emergency drug kit (EDK). If not available I would get it (medication) from the pharmacy. I personally call the pharmacy and ask why the medication was not here. If I can't get it immediately, I would document at that time and the resident would go without. "If I don't have it, I don't have it." LPN #2 indicated, all nurses are responsible for reordering medications. "We can order stat [immediately]." LPN #2 indicated if the medication was given later it should be documented. The clinical record lacked documentation of omitted medication being administered at a later time.</p> <p>On 12/22/15 at 12:40 p.m., the Director of Nursing (DON) indicated when medication is not available for a resident the nurses check the emergency drug kit (EDK) and if not available call the pharmacy. "They wait for the medication to come from backup." The DON indicated the local hospital was not sending the resident's hard copy prescription.</p>			

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	<p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, indicated, "... Xarelto ...Black box warning: Discontinuing ...places patients ...at increased risk for thrombotic (blood clot) events. ...PATIENT TEACHING: ...not to discontinue drug without consulting prescriber. ...if a dose is missed , to take dose ... soon ..."</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, indicated, amiodarone ...Black Box Warning: "...is intended for use only in patients with life threatening recurrent ventricular fibrillation ...PATIENT TEACHING: ...Tell patient not to stop taking this medication without consulting with his prescriber ..."</p> <p>4). Resident #E's clinical record was reviewed on 12/22/15 at 9:00 a.m., Diagnoses included, but were not limited to: malignant neoplasm and gastro esophageal reflux disease.</p> <p>Physician's orders dated 11/7/15 through 12/22/15, indicated, Bactrim DS (antibiotic) 800-160 mg twice a day.</p> <p>The Medication Administration History indicated on the following dates medications were not available as ordered to administer to Resident #D:</p>			

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	<p>On 11/8/2015, for 6:00 a.m.- 10:00 a.m., and 6:00 p.m.- 10:00 p.m., medication administration Bactrim 800-160 mg were not administered.</p> <p>The clinical records lacked documentation indicating the missed medications were given at a later time.</p> <p>On 12/22/15 at 9:02 a.m., the Director of Nursing (DON) indicated, medications on the skilled nursing unit are reordered electronically by pushing a button on the computer under the resident's profile.</p> <p>On 12/22/15 at 11:49 a.m., an interview with Licensed Practical Nurse (LPN) #1 indicated, when ordered medication is not available, she would notify the physician, pharmacy, and patient's family. "We would take the medication out of the emergency drug kit (EDK) if available. If not we call the backup pharmacy. The medication should be reordered when down to a couple of pills." LPN #1 indicated all nurses are responsible to reorder medication. The medication card has a notice saying to reorder now. LPN #1 indicated would document medication not given and unavailable.</p> <p>On 12/22/15 at 12:01 p.m., an interview with Licensed Practical Nurse (LPN) #2</p>			

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	<p>indicated, if resident's order medication was not available I would check the emergency drug kit (EDK). If not available I would get it (medication) from the pharmacy. I personally call the and ask why the medication was not here. If I can't get it immediately, I would document at that time and the resident would go without. "If I don't have it, I don't have it." LPN #2 indicated, all nurses are responsible for reordering medications. "We can order stat [immediately]." LPN #2 indicated if the medication was given later it should be documented. The clinical record lacked documentation of omitted medication being administered at a later time.</p> <p>On 12/22/15 at 12:40 p.m., the Director of Nursing (DON) indicated when medication was not available for a resident the nurses check the emergency drug kit (EDK) and if not available call the pharmacy. "They wait for the medication to come from backup." The DON indicated the local hospital was not sending the resident's hard copy prescription.</p> <p>On 12/22/15 at 10:20 a.m., the Director of Nursing provided a policy, without title " dated March 2015, and indicated the policy was the one currently used by the facility. The policy indicated, "...XI.</p>			

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	<p>RESPONSIBILITY ...6. ...Responsibility to order medications before the stock is depleted. Responsibilities for administering medications ordered. Note: withholding medications due to medication not being available is not acceptable-first check the EDK box, if the medication is not in there then call the pharmacy and let someone know that the medication is completely out. ..."</p> <p>On 12/22/15 at 1:00 p.m., the Director of Nursing provided the policy "Medication Pass Procedure and Error Prevention" dated March 2015, and indicated the policy was the one currently used by the facility. The policy indicated, "I. AT THE START OF MED PASS ... Check for adequate supplies, ..."</p> <p>This Federal tag is related to Complaint IN00187607.</p> <p>3.1-37(a)</p>						