STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 MARGARET AVE TERRE HAUTE, IN 47802

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00433856, IN00433635, IN00433447, and IN00432386. Complaint IN00433856 - No deficiencies related to the allegations are cited. Complaint IN00433635 - Federal/State deficiencies related to the allegations are cited at F755. Complaint IN00433447 - No deficiencies related to the allegations are cited. Complaint IN00432386 - No deficiencies related to the allegations are cited. Survey dates: May 14, 15, 16, and 17, 2024 Facility number: 000564 Provider number: 155484 AIM number: 100285610 Census Bed Type: SNF/NF: 105 Total: 105 Census Payor Type: Medicare: 4 Medicaid: 85 Other: 16 Total: 105 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 30, 2024.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer White	Director of Nursing	06/05/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to maintain a system for the reconciliation of narcotic medications	F 0755	We respectfully request a desk review. **F755**	06/17/2024

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	resulting in two separate occasions of drug diversion for 1 of 3 residents reviewed for medication reconciliation (Resident C). Findings include: 1. An Indiana State Department of Health (ISDH) Survey System report, dated 4/22/24 at 1:30 a.m., submitted by the facility indicated one card of Resident C's Norco (narcotic medication used to relieve moderate to severe pain) was missing. Qualified Medication Aide (QMA) 6 and Registered Nurse (RN) 5 were suspended pending investigation. The pharmacy and Police Department were notified of the missing narcotic medication. On 5/14/24 at 9:32 a.m., the Administrator (ADM) indicated the facility could not prove who took the missing narcotic medication card of Norco. On 5/14/24 at 11:55 a.m., the Director of Nursing (DON) indicated she did part of the investigation of the missing narcotic card and the Corporate Registered Nurse Consultant (RN) 4 did part of the investigation. She was typing up the investigation timeline of the Norco missing narcotic medication card and missing narcotic count sheet incident. Resident C's clinical record was reviewed, on 5/14/24 at 3:10 p.m. Resident C was admitted to the facility on 4/17/24 and discharged to home on 4/29/24. The diagnoses included, but were not limited to, diabetes mellitus (high blood sugar), hypertension (high blood pressure), and fibromyalgia (chronic disorder characterized by widespread pain). An admission Minimum Data Set (MDS)		**Corrective actions accomplished for those residents found to be affected by the alleged deficit practice**: Resident C was not harmed by the alleged deficient practice. Resident C no longer resides at the facility. The facility notified pharmacy to reverse the charges for the missing narcotics and bill the facility. **Identification of other residents having the potential to be affected by the same alleged practice and corrective actions taken:** All residents that have a physician's order for narcotics have the potential to be affected. The facility completed an audit of all narcotics utilizing the pharmacy delivery sheets from 4/5/24 through 5/17/24 to validate that no other residents had narcotics missing. The facility also searched all med carts, narcotic boxes, med rooms, offices and shred boxes. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** The facility completed education with the licensed nurses and QMAs utilizing the policy "Medication Controlled Drugs and Security" and "Medication Administration" with emphasis on counting	

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	assessment, dated 4/23/24, indicated the resident was cognitively intact and prescribed an as needed pain medication regimen, his pain frequency was occasional, and the pain intensity was rated a 4 out of 10, with 10 being the worst pain experienced. A care plan, dated 4/17/24, indicated the resident had complaints of acute/chronic pain or was at risk for pain. Interventions included, but were not limited to, follow physician's order for complaint of pain. A 4/17/24 physician's order indicated Resident C was prescribed acetaminophen (Tylenol) oral tablet 500 milligrams (mg), 1 tablet by mouth every 6 hours as needed for pain. A 4/17/24 physician's order indicated Resident C was prescribed hydrocodone-acetaminophen (APAP) oral tablet 5-325 mg, 1 tablet by mouth every 4 hours as needed for moderate pain (4-10). A 4/25/24 physician's order indicated Resident C was prescribed tramadol hydrochloride (HCL) oral tablet 100 mg, 1 tablet by mouth every 6 hours as needed for post-surgical pain for 10 days. A 4/17/24 pharmacy invoice indicated the resident had 24 tablets of hydrocodone-APAP 5-325 mg delivered to the facility. A 4/22/24 pharmacy invoice indicated the resident had 6 tablets of hydrocodone-APAP 5-325 mg delivered to the facility. A 4/26/24 pharmacy invoice indicated the resident had 30 tablets of tramadol 100 mg delivered to the facility.		number of cards and inventory sheet, how to handle a discrepancy, handling discontinued narcotics and signing administration in medical chart to secure the medications appropriately. The RDCO completed education with DON on documenting drug destruction in the pharmacy portal on 5/18/24. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** On 5/17/24 the facility replaced all narcotic inventory books and did a complete facility count establish a new baseline for count. The DON/Designee began observing shift to shift narcotic counts on 5/18/24 at each shift change for 30 days to ensure narcotic counts are conducted each shift and no discrepancies are found. The observations will continue 5 times per week for 4 weeks on random shifts after the 30 days are completed, then 3 times per week on random sheets for 4 weeks. The facility is also validating through observation the pharmacy delivery sheets to the actual card each day to ensure all medications are accounted for. The RDCO will complete a weekly audit for narcotic destruction to ensure DON is following policy. **Any discrepancies will be corrected immediately and education will be provided.**	

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	On 5/15/24 at 11:20 a.m., DON provided the documentation of the investigation timeline of Resident C's missing Norco narcotic medication card and missing Norco narcotic count sheet. She indicated, on 4/22/24 at about 1:30 a.m., Registered Nurse (RN) 5 reported to Licensed Practical Nurse/Unit Manager (LPN) 7 a whole medication card with 24 tablets of Norco and the narcotic count sheet were missing for Resident C. On 4/22/24 at about 8:30 a.m., LPN 7 reported to the DON that the medication card and narcotic count sheet were missing. Staff did a facility search of the medication carts, narcotics books, pharmacy records, and Resident C's electronic medical record to try to match the orders and observed what was missing until about 9 p.m. and staff could not find anything. On 4/24/24, DON notified the facility's corporate office RN 4 of the missing narcotic card and missing narcotic count sheet and that staff were unable to determine where the missing narcotic card and narcotic count sheet went. On 5/16/24 at 9:00 a.m., RN 4 indicated when the facility found a drug diversion, they should do a facility wide search for the narcotic itself in the medication room, medication carts, offices, and overflow to see if the drug was misplaced. If staff did not find it, the corporation was notified, and the corporation offered guidance of how to handle the drug diversion investigation. Typically, the DON made an investigation timeline and documented interviews and any residents' assessments on the timeline. Staff documented when notification was given to the State, police, the resident and family, and the Medical Director. The corporation advised the facility to do a 3-day lookback of what led up to the event. If staff found concerns further back, the facility would have started the investigation from that lookback		**The results of audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation**	

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	point. RN 4 indicated the facility and DON would have included all residents that received narcotics and all staff members that would have information regarding the event. RN 4 was notified the narcotics were missing and told DON to start the investigation, advised to notify police, notify the resident and family, interview all employees who had access to the medication cart, complete pain assessments on all the residents who received narcotic pain medications, and ensure all residents received their pain medications as ordered. RN 4 indicated she had interviewed Qualified Medication Aide (QMA) 9 about the missing narcotic medication care and narcotic count sheet situation. QMA 9 told RN 4 that she did not have the medication cart, on Friday 4/19/24, but did have the medication cart on 4/20/24. QMA 9 indicated she did not have pain medications to pass and did not get into the narcotics drawer on 4/20/24. The count in the narcotics book was 7 medication cards and 6 narcotic count sheets and that was what was counted on the previous shift. So, QMA 9 did not assume anything was wrong. On Sunday 4/21/24 at 6 a.m. the count was still the same for QMA 9 and LPN 16. On Sunday 4/21/24 at 10:00 p.m., the count was done with RN 8 and QMA 9 and was the same count as before. Resident C had requested a pain pill from QMA 9. So, she went to the medication cart and did not find the card nor the count sheet for the medication. QMA 9 went to RN 5 and asked if the Resident C's order for Norco had been discontinued or was an active order. RN 5 notified LPN 7 of the missing narcotic drug card and missing narcotic count sheet of Norco. LPN 7 and RN 5 searched the facility medication rooms and medication carts. RN 5 instructed QMA 9 to give Resident C a Tylenol. QMA 9 indicated that seemed to help with his pain. QMA 9 had looked at the narcotic book and noticed the count had			

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	changed on 4/19/24 and had previously been 8 narcotic medication cards and 7 narcotic medication count sheets. There was no documented removal on the narcotic card nor narcotic count sheet for Resident C's Norco. The narcotic count record had changed on 4/19/24 from 8 narcotic cards and 7 narcotic count sheets to 7 narcotic cards and 6 narcotic count sheets without documentation of removal from the medication cart. The DON was to interview staff and investigate the drug diversion. The facility set up an event call with the corporation to let them know the status of the situation and what needed to be done from that point forward. On 4/24/25, the DON was instructed to contact the pharmacy about the Norco and let them know it was missing and have the Nurse Practitioner (NP) assess Resident C for pain and his needs. The NP changed the resident's order from Norco to tramadol. RN 5 and QMA 6 were suspended pending investigation, the pharmacy and Police Department were notified of the missing narcotic medication card and narcotic count sheet. The 2 staff members were brought back to work after the 5-day suspension because the facility could not determine who had taken the narcotic. The corporation advised the facility to complete in-service education of narcotics handling and storage, and review how to fully complete the narcotic count and inventory sheet. The facility was advised by corporate that the number of narcotic cards, narcotic count sheets, and validating the electronic medication administration record (EMAR) should be completed daily. On 5/16/24 at 12:05 p.m., RN 5 indicated she did not take the narcotic medication. On 4/19/24, she worked from 2:00 p.m. to 4/20/24 at 6:00 a.m. She was originally assigned 100 hall and then switched to 200-back hall, which included			

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	Resident C. RN 5 administered to Resident C at about 8:30 p.m. on 4/19/24, a Norco tablet. RN 5 finished the residents' medication pass for the 200-back hall and at 10:00 p.m. RN went back to the 400 and 500 halls to work. On 4/22/24, QMA 9 had notified RN 5 that there was a missing narcotic's card of Norco medication for Resident C. LPN 7 was notified that night of the missing medication card and narcotic count sheet. RN 5 indicated she did not take the narcotics medication card. On 4/19/24, the narcotic book count sheet showed RN 5's initials, but she indicated she had not signed the narcotic count sheet, because she had forgotten to initial the document and someone else had placed her initials on the narcotic count sheet. The next day, on 4/20/24, RN 5 indicated she was talking with QMA 12 and QMA 12 had indicated she gave Resident C a Norco on 4/20/24 in the morning. RN 5 indicated she sometimes forgot to document when an as needed medication was administered to a resident in the electronic medication administration record (EMAR). On 5/16/24 at 1:05 p.m., ADM reviewed the 4/19/24 narcotic count sheet and indicated that RN 5's initials on the narcotic count sheet did not match the other times RN 5 had signed the narcotic count sheets. ADM indicated she did not believe RN 5 had taken the narcotic medication card and narcotic count sheet, but she was unable to determine where the medication card and count sheet went. On 5/16/24 at 2:08 p.m., DON indicated staff had notified Resident C of the missing Norco medication. She had handwritten the notification of the missing Norco medication to Resident C, dated 4/25/24, but the information was not documented in the resident's electronic health			

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	record. On 5/16/24 at 2:38 p.m., QMA 6 indicated she did not take any medications from the facility. She came to work on 4/19/24 from 6:00 p.m. to 10:00 p.m. and worked on the 400 and 500 halls medication cart, then at 10:00 p.m., she was assigned to work all the medication carts from 10:00 p.m. to 6:00 a.m., including 200-back hall medication cart. On 4/19/24, she was assigned the 200-back hall cart from RN 5 and the narcotics card count was right at 8 medication cards and 7 medication count sheets, when she came on at 10:00 p.m. On 4/20/24 at 6:00 a.m., she was the off nurse and put her initials and the date of "4/20" on the "Shift Change/Controlled Substance Inventory Tracker" and left the remainder of the document, the time and card/sheet count, were blank when she left the facility, because the oncoming nurse, QMA 12, was in the bathroom throwing up due to morning sickness. QMA 6 indicated she had called off sick on 4/21/24 and on Monday 4/22/24, she was off work. When she came back to work, on Tuesday 4/23/24, somebody had filled out the narcotics count sheet for 4/20/24 at 6:00 a.m. of 7 medication cards and 6 medication count sheets. QMA 6 indicated she did not get into the narcotics drawer nor administered Resident C any Norco pain medication. No one had access to the medication cart keys while on her shift. She did not realize, at the time, that she had left the narcotics card, and the narcotics count sheet blank, and it did not dawn on her to go back and complete the narcotics count sheet documentation. Someone else had filled it in, on 4/20/24 at 6:00 a.m., the time and the narcotics cards and narcotics count sheet of 7 and 6. She did not take the narcotics. On 5/15/24 at about 7:00 p.m., the DON called QMA 6 and indicated to QMA 6 that she was suspended			

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	with pending investigation from work, because QMA 6 had signed out a narcotics card of Resident C's tramadol, on 4/30/24 at 2:00 p.m., with LPN 13 and the entire medication card of Resident C's tramadol was missing. On 5/16/24 at 3:45 p.m., DON indicated the facility had submitted to ISDH a reportable with incident dated: 5/15/2024 and incident time: 6:15 p.m., of Resident C's missing card of tramadol medication with 24 tablets. The corporation told the facility staff not to mention the submitted ISDH reportable for the same resident, Resident C. 2. An Indiana State Department of Health (ISDH) Survey System report, dated 5/15/24 at 6:15 p.m., submitted by the facility indicated one card of Resident C's tramadol (narcotic medication used to relieve moderate to severe pain) was missing. QMA 6 and LPN 13 were suspended pending investigation. The pharmacy and Police Department were notified of the missing narcotic medication. On 5/17/24 at 8:35 a.m., ADM indicated the facility had put in a plan of action in place to have all clinical managers check daily all the narcotics medication cards and all narcotic medication count sheets reviewed for a minimum of 30 days and then see how the audits went from there. On 5/17/24 at 9:25 a.m., RN 4 indicated, staff could not find the tramadol medication destruction sheet and that was the reason the facility had submitted a reportable on it to ISDH. The DON should have, but was not completing disposition logs of medications destroyed at the facility. She was not able to locate any discharge medication documentation for Resident C's discharge to home on 4/29/24 in Resident C's medical record.			

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	On 5/17/24 at 10:20 a.m., DON and RN 4 provided the ISDH 5/15/24 reportable and the timeline for Resident C's missing narcotic tramadol investigation documentation, completed thus far. The timeline indicated, on 5/15/24 at 1:00 p.m., the DON was notified by LPN 17 and LPN 18 of Resident C's missing tramadol medication card and count sheet. A facility search was initiated, including clinical offices, medication rooms, overstock medications, medication carts, clean and soiled utility rooms, shred-it boxes, and the inventory sheet with the tramadol narcotic medication was not able to be located. At 1:46 p.m., the DON notified the ADM and RN 4 of the missing narcotic tramadol medication card and the controlled drug administration record for Resident C. RN 4 directed the DON to continue with the facility search, obtain statements from nursing staff from 4/29/24 to 5/1/24 working on the 200-back hall cart responsible for medication administration to Resident C and also conduct pain audits and assessments on all residents receiving narcotics in the facility. Upon the DON's investigation, it was discovered that Resident C's tramadol was signed as removed by LPN 13 and QMA 6. DON then notified Human Resources (HR) at 5:00 p.m., of LPN 13 and QMA 6 suspensions pending investigation. On 5/16/24 at 2:00 p.m., RN 4 interviewed QMA 6. QMA 6 indicated she worked, on 4/19/24 at 6:00 p.m., on the 400 and 500 halls until 10:00 p.m. QMA 6 counted with QMA 12, and the count was correct. She assumed the keys for all the medication carts for the whole building at 10:00 p.m. She counted with all the off-going nurses and the medication counts were right. RN 5 was on break, so QMA 6 counted 200-back hall by herself. QMA 6 noticed Resident C's Norco			

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	medication tab needed to be signed out, so RN 5 signed it when she came back. QMA 6 did not give Resident C a pain pill but remembered having some in the medication cart for him. At 6:00 a.m., QMA 12 took the 200-back hall medication cart but did not count the medication cards and count sheets because she was having morning sickness from being pregnant. QMA 6 got tired of waiting for QMA 12, so she left. At 2:10 p.m., when QMA 6 came back QMA 12 was already gone, and RN 8 had counted with QMA 12. RN 8 told QMA 6 she would keep the medication cart. At 10:00 p.m., QMA 6 worked the floor as a Certified Nursing Aide (CNA). On Sunday, 4/21/24, QMA 6 called into work sick. The narcotic count book, on 4/20/24, was not in her handwriting for the date and time but that was her signature. QMA 6 indicated she did not work again until Tuesday 4/23/24. She had all the medication carts, and the medication sheet counts were right. On 5/1/24, QMA 6 was assigned 200-back hall medication administration and took the medication cart from LPN 11. LPN 11 handed QMA 6 the 200-back hall medication cart keys and said she was tired and went home around 8:30 p.m. or 9:00 p.m. QMA 6 counted the medication narcotic cards and narcotic count sheets by herself, and the count was correct. Resident C's tramadol was not on the medication cart as far as she could remember. On 5/1/24, the signature in the medication narcotic book was not hers because she did not get to the building until 10:00 p.m. On 5/17/24 at 9:01 a.m., ADM provided QMA 6's timecard for 5/1/24 and the ADM indicated QMA 6 worked on 5/1/24 from 6:05 p.m. to 5/2/24 at 6:40 a.m. On 5/16/24 at 4:45 p.m., during the staff interview with LPN 11, she indicated, on 5/1/24, LPN 11 took			

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	155484	A. BUILDING 00 B. WING	05/17/2024

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	the 200-back hall medication cart from LPN 13. LPN 11 completed the medication narcotics count with LPN 13 and the narcotics count was correct. LPN 11 worked four hours until 6:00 p.m. and then gave the medication cart to QMA 6. LPN 11 was not aware that QMA 6 had indicated in her interview that on 5/1/24 QMA 6 did not take the medication cart keys from LPN 11 until 8:30 p.m. to 9:00 p.m. with LPN 11 stating to QMA 6 that she was tired and going home and did not count the medication cart together. LPN 11 indicated she did count the narcotic medication cards and narcotic medication count sheets with QMA 6. QMA 6 took the medication cart keys at 6:00 p.m. and the medication narcotics count and count sheets were correct. LPN 11 could not recall giving any as needed pain medications on that shift, could not recall anyone giving her any empty cards nor asking her to remove any cards from the medication carts for discontinued orders. Her process for taking over a medication cart was giving report and counting the narcotic medications with another staff. If LPN 11 was coming on to a shift, she counted the number of pills and the off going staff says the number on the inventory sheet. We counted the number of cards and the number of sheets. When a narcotic medication card needed to be removed from the medication cart, then LPN 11 and another manager would remove it from the cart and take the medication card to the DON. On 5/15/24, we realized Resident C's card of tramadol was missing. We searched every medication cart, medication room, shred-it box, and refrigerator and could not locate the medication. We then initiated an investigation. The ADM, on 5/14/24 at 11:45 a.m., indicated the facility could not prove who took the missing narcotic medication cards and the ADM provided			

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	and identified an undated document as a current facility policy, titled, "Medication Controlled Drugs and Security." The policy indicated, "...Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...narcotics will be kept under double lock and will be counted by on-coming and off-going nurse at the end of each shift and before keys are passed to next shift. The purpose of this policy is to provide direction for the nurse regarding processes of operation for the administration and control of narcotics, depressants, and stimulant drugs and to provide maximum safety for residents and nursing personnel...Procedure: I. Controlled drug distribution is for use of residents only...b. A record is retained for all drugs destroyed by licensed personnel and by individual state guidelines...d. Drug diversion will be treated as misappropriation of Resident Property and the Board of Nursing will be notified as appropriate for known drug diversions or suspected drug diversion after careful review and evidence collection...II. The Narcotic Box...a. A separate locked compartment for controlled drugs is provided within a locked cabinet...b. The compartment has a special lock and key and must be kept locked at all times when not being immediately accessed by the nurse or qualified medication aide...III. The Narcotic Key...a. The narcotic key shall be in the possession of the nurse or qualified medication aide where applicable, during the entire tour of duty...b. Narcotic keys will be transferred after the narcotic count is completed and verified current whether the transfer of key occurs end of shift or during a shift...c. Narcotic keys are to remain on the unit in the possession of licensed personnel to count and hold the keys...d. Narcotics will be counted at			

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	change of shift and upon being relieved from duty, the licensed personnel shall transfer the key to the qualified staff accepting responsibility for the count...e. The narcotic key is not to be given to others; the nurse is accountable for the location of the key at all times...IV. The Narcotic Count and Inventory...a. Controlled drugs as well as the controlled drug count sheets and cards, are counted every shift change by the nurse reporting on duty with the nurse reporting off duty...b. The inventory of the controlled drugs count sheets and number of cards must be recorded on the narcotic records and signed for correctness of count...c. The controlled drug record must be signed by the nurse coming on duty and going off duty to verify that the count of all controlled drugs is correct after the count has been completed...V. Discrepancy in Count...a. In the event a discrepancy is found, check the resident's medication sheets and chart to see if a narcotic has been administered and not recorded...b. Check previous recordings on the control sheets for mistakes in arithmetic...c. If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the supervisor for immediate investigation...d. Nurses or qualified medication aide may not leave the unit until directed to do so by the immediate supervisor...e. The incident will be investigated and reported to the Administration leadership...VI. Irregularities during Count...d. Any suspicion of substitution or tampering with controlled drugs must be reported to the DON immediately...e. DON will notify consultant pharmacist and administrator immediately for further action...VII. Discontinuing Narcotics/Controlled Substances...a. When the prescribed drug is discontinued, or the resident discharged, the container and control sheet must be removed for drug destruction...."			

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	This citation relates to Complaint IN00433635. 3.1-25(a) 3.1-25(b)(1) 3.1-25(c)			