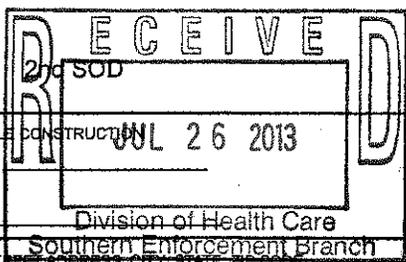


DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 07/19/2013
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 06/13/2013
NAME OF PROVIDER OR SUPPLIER IRVINE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40336	

(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	F 000	F281 Meet professional standards.	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for one of three sampled and one unsampled Resident (Resident A). Resident A had physician's orders for Coumadin (anticoagulant) to be "held until further notice" and to repeat Prothrombin Time/International Normalized Ratio (PT/INR) on "Thursday" (06/06/13); however, facility staff failed to ensure the PT/INR was obtained on Thursday, 06/06/13, prior to starting Coumadin, as ordered by the physician.</p> <p>The findings include: An interview with the facility's Nurse Consultant (NC) on 06/13/13, at 5:40 PM, revealed the facility did not have a specific policy related to following physician's orders. However, according to the NC, it would be expected that licensed staff would obtain labs for PT/INR as ordered by the physician and the physician would be made</p>	F 281	<p>1. Resident A was immediately assessed and the physician was notified by the Unit Manager (UM) on 6/13/2013 that lab was not obtained as ordered and that the resident received Coumadin that day and everyday since the order on 6/4/2013. An order was obtained to complete a stat PT/INR and the result showed a normal INR. New orders were obtained and the family was notified. Resident A suffered no effects from receiving the Coumadin. The Medical Director was also notified of the medication error on 6/13/2013 by the Unit Manger (UM). Pharmacy was notified of the medication error by the Nurse Consultant on 6/14/2013.</p> <p>2. A review of every residents record receiving Coumadin was immediately completed on 6/13/2013 by the Nurse Consultant (NC), Director of Nursing (DON) and the Unit Manager (UM) to identify any resident that received Coumadin without an order, any resident who did not have PT/INR obtained in the last 60 days from 6/13/2013 per physician order and that MAR was correct and reflected the most current order for Coumadin. No other issues were identified.</p> <p>A one time audit of physicians orders will be completed by the DON, UM and/or the NC by 7/9/2013 to identify any resident who has an order for a lab from 1/1/2013 thru 6/25/2013 that was not completed per physician order or any drug that requires a level has an order for a level periodically.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Lisa Johnson, Administrator* TITLE: ADMINISTRATOR (X6) DATE: 7/25/13

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 281	<p>Continued From page 1 aware of the results.</p> <p>A review of the medical record for Resident A revealed the facility admitted Resident A on 11/24/12 with diagnoses that included Altered Mental Status, Hypertension, Atrial Fibrillation, and Diabetes Mellitus. A review of physician's orders dated 06/04/13 revealed the resident was to receive 2 mg of Coumadin by mouth once a day except for Tuesdays and Thursdays; and 3 mg of Coumadin by mouth every Tuesday and Thursday. A review of Resident A's lab results on 06/04/13 revealed the resident's INR was 9 (reference range 2.0-3.0) and the physician requested for the administration of the Coumadin to be "held" until further notice and to repeat the PT/INR on Thursday (06/06/13). A review of the medical record revealed no evidence that a PT/INR had been obtained on 06/06/13 as requested by the physician. Also, a review of physician's orders revealed there was no order to restart Coumadin.</p> <p>A review of Resident A's Medication Administration Record (MAR) from 06/01/13 through 06/13/13 revealed staff had administered 2 mg of Coumadin once a day except on Tuesdays and Thursdays; and 3 mg of Coumadin every day on Tuesday and Thursday as requested by the physician. Further review of the MAR revealed staff did not administer the Coumadin on 06/04/13 through 06/07/13. However, staff restarted the administration of the Coumadin on 06/08/13 even though an order to restart the Coumadin was not noted in the medical record.</p> <p>An interview with Certified Medication Technician</p>	F 281	<p>A One time audit will be completed by 07/09/13 to identify any medication order that was not transcribed per physician order from 4/1/2013 thru 6/25/2013 by Unit Manager. Any issue identified will be immediately reported to the physician and family.</p> <p>A one time audit will be conducted for all physicians orders by 07/12/13 to identify if they are transcribed correctly and on the MAR correctly, Family has been notified and Meds are being administered per policy. Any issues will be corrected immediately with MD and Family made aware.</p> <p>10 random employees will be observed providing care by 07/25/13 by UM and/or ETD to identify any issues with staff meeting professional standards of care. If any issues are identified, one on one re-education will occur by Unit Manager.</p> <p>All Physicians orders will be reviewed in Daily clinical review Monday-Friday by Unit Manager, DON on an ongoing basis and checked against the MAR to identify any problems with taking physicians orders and posting to the MAR.</p>		

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F 281	<p>Continued From page 2</p> <p>(CMT) #1 on 06/13/13 at 4:46 PM revealed that she had not been notified to "hold" the Coumadin ordered for Resident A. CMT #1 stated that she had been taught to review the MARs when she administered medications and stated, "I came in at 3:00 PM and no one told me not to give the Coumadin."</p> <p>An interview conducted on 06/13/13, at 5:40 PM, with the NC revealed the Unit Manager was responsible for making sure that lab orders were put into the computer so they would know when the labs are due.</p> <p>An interview conducted on 06/13/13, at 4:35 PM, with Unit Manager #1 revealed she had taken the physician orders off on 06/04/13 and put the Coumadin for Resident A on hold for four days, but failed to enter the laboratory request into the computer. She stated, "I guess I just forgot." Unit Manager #1 said she had identified the error "today" (06/13/13) at 2:30 PM, while doing chart reviews. According to the UM, she "paged the physician, notified him of the medication error and the resident had no adverse reactions from receiving the Coumadin that was ordered to be on hold." Unit Manager #1 said that she reported this information to the second shift Unit Manager (UM #2) at 2:45 PM.</p> <p>An interview was conducted on 06/13/13 at 4:55 PM, with Unit Manager #2, which revealed that she was made aware of the medication error "today" (06/13/13) at 2:45 PM. She said that she did not tell the Certified Medication Technician (CMT) not to administer the Coumadin to Resident A and stated, "The physician had been notified, and we were getting an INR drawn."</p>	F 281	<p>3. The Education and Training Director (ETD) will re educate all licensed nursing staff and all KMAs (medication aides) regarding following physician order for all medications, following physician orders for obtaining labs, transcribing medications per physician orders and procedure to obtain labs per physicians order, the eight rights of medication pass, what drugs require a level, what is a medication error and how to correctly discontinue any medication,. This will be completed by 7/9/2013. The ETD will re-educate all nursing staff on professional standards and following policy while providing care by 07/25/13</p> <p>The NC re educated the DON, UM, ADON and ETD on 6/13/2013 regarding procedure to follow up on every physician order, eight rights of medication pass, what to notify physician about, what drugs require levels and procedure to discontinue Coumadin and re write order to ensure that all staff giving medications know when Coumadin or any drug is not to be given.</p> <p>Beginning 6/27/2013 all change in Coumadin orders will be brought to the Interdisciplinary meeting 5 x week to verify that order is followed and that Coumadin is on the MAR correctly.</p> <p>Beginning the week of 6/20/2013 the NC will audit all Coumadin orders 2 x monthly x 3 months to ensure all Coumadin orders are transcribed correctly, all PT/INR orders are followed and that all changes are brought to the IDT meeting.</p>		

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F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free of significant medication errors for one of three sampled and one unsampled residents (Resident A). Physician orders written on 06/04/13 revealed the physician requested for facility staff to "hold" Resident A's Coumadin (anticoagulant) until "further notice" and to obtain a Prothrombin Time/International Normalized Ratio (PT/INR) laboratory test on "Thursday" (06/06/13). Record review revealed facility staff did not administer Resident A's Coumadin for four days and restarted the Coumadin on 06/08/13 without repeating the lab or having a physician's order to administer the Coumadin.</p> <p>The findings include:</p> <p>The facility admitted Resident A on 11/24/12, with diagnoses that included Altered Mental Status, Hypertension, and Diabetes Mellitus.</p> <p>A review of Resident A's physician's orders dated 06/04/13, revealed the resident was to receive Coumadin on a daily basis. However, on 06/04/13 the physician requested for staff to "hold" the Coumadin until further notice and to obtain a "repeat" PT/INR test on "Thursday" (06/06/13). A review of Resident A's labs</p>	F 333	<p>Beginning week of 7/9/2013 the DON or the NC will audit at least 15 physicians orders weekly x 4 weeks then 10 random orders weekly x 4 weeks to ensure that all orders are followed per physician orders and that UM is validating the orders per this plan.</p> <p>Beginning the week of 07/08/13- UM and/or ETD will monitor 5 staff members weekly providing care to ensure clinical competency is being performed per professional standards x 4 weeks.</p> <p>Beginning the week of 7/9/2013 the UM and/or DON will audit 15 records x 4 weeks to ensure all leveled drugs have orders for labs to monitor and that they are obtained per physicians order and that labs on the draw list are completed per order.</p> <p>Beginning the week of 7/9/2013 the UM, DON will review 10 residents' physician orders looking back 30 days weekly for 4 weeks to ensure all orders are on the MAR correctly and that all drugs are in the medication cart with the correct directions for administration.</p> <p>Pharmacy consultant to monitor medication pass to at least 3 patients monthly beginning 7/2013. Any issues will be reported to physician and family.</p> <p>4.The QA Committee consisting of at least Administrator, DON,UM, ADON,Medical Director, Social Services,ETD and Activities Department will meet monthly beginning 7/2013 to review audit findings, make recommendations and review this plan. This process will be on going until this issue is considered resolved.</p>		

5. Date of Compliance 7/25/2013.

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F 333	<p>Continued From page 4 completed on 06/04/13 revealed an INR of 9 (reference range 2.0-3.0).</p> <p>A review of Resident A's Medication Administration Record (MAR) for June 2013 revealed facility staff held the resident's Coumadin on 06/04/13 through 06/07/13 and restarted the Coumadin on 06/08/13. However, it could not be determined by a review of physician's orders that the physician had requested facility staff to continue to administer the Coumadin to Resident A.</p> <p>On 06/13/13 at 3:51 PM, during observation of a medication pass, facility staff administered 3 mg of Coumadin to Resident A.</p> <p>Interview with Certified Medication Technician (CMT) #1 on 06/13/13 at 4:46 PM revealed that she was trained to follow the MARs when she administered medications. CMT #1 stated there had not been any other "holds" written on the MARs after 06/07/13. According to CMT #1, "No one told me not to give the Coumadin."</p> <p>An interview was conducted with Unit Manager #1 on 06/13/13 at 4:46 PM. The UM stated that she had transcribed the physician's order from Resident A's medical record on 06/04/13 and had put "HOLD" on the MARs from 06/04/13 through 06/07/13. Unit Manager #1 stated, "I forgot to put the labs into the computer." Unit Manager #1 said that she had identified the medication error at 2:30 PM on 06/13/13 (the day of the interview) while doing chart reviews. The UM stated she then notified the physician of the medication error and informed him that Resident A had not experienced any adverse reactions from receiving</p>	F 333	<p>F333</p> <p>1. Resident A was immediately assessed and the physician was notified by the Unit Manager (UM) on 6/13/2013 that lab was not obtained as ordered and that the resident received Coumadin that day and everyday since the order on 6/4/2013. An order was obtained to complete a stat PT/INR and the result showed a normal INR. New orders were obtained and the family was notified. Resident A suffered no effects from receiving the Coumadin. The Medical Director was also notified of the medication error on 6/13/2013 by the Unit Manger (UM). Pharmacy was notified of the medication error by the Nurse Consultant on 6/14/2013.</p> <p>2. A one time review of every residents medical record who receives Coumadin was immediately completed on 6/13/2013 by the Nurse Consultant (NC), Director of Nursing (DON) and the Unit Manager (UM) to identify any resident that receives Coumadin had an order present and that a PT/INR was obtained in the last 60 days from 6/13/2013. Audit also verified that physician order and that MAR was correct and reflected the most current order for Coumadin. No issues were identified.</p> <p>A one time audit of physicians orders will be completed by the DON, UM and/or the NC by 7/9/2013 to identify any resident who has an order for a lab from 1/1/2013 thru 6/25/2013 that was not completed per physician order or any drug that requires a level has an order for a level periodically.</p>	

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F 333	<p>Continued From page 5</p> <p>the Coumadin. New orders were received to obtain a PT/INR and to report the results to the physician. Unit Manager #1 stated she reported the physician's request to the second shift supervisor, Unit Manager #2, at 2:45 PM.</p> <p>Interview conducted with Unit Manager #2 on 06/13/13 at 4:55 PM, revealed that she was made aware that the Coumadin "was in question" on 06/13/13 at 2:45 PM; however, the Unit Manager stated she had failed to inform the CMT that Coumadin was not to be administered to Resident A until new orders were received from the physician.</p> <p>Interview with the Nurse Consultant on 06/13/13 at 5:40 PM revealed it was the Unit Manager's responsibility to enter the laboratory requests into the computer and, when the laboratory results became available, to notify the physician of the findings and to receive additional orders as determined by the physician.</p>	F 333	<p>A One time audit will be completed by 07/09/13 to identify any medication order that was not transcribed per physician order from 4/1/2013 thru 6/25/2013 by Unit Manager. Any issue identified will be immediately reported to the physician and family</p> <p>A one time audit will be conducted for all physicians orders by 07/12/13 to identify if they are transcribed correctly and on the MAR correctly, Family has been notified and Meds are being administered per policy. Any issues will be corrected immediately with MD and Family made aware.</p> <p><i>See Attached Additional Pages For continuation of #2, #3, #4 + #5</i></p>		

F333 Continuation - ACC. pg. 7

Beginning 6/27/2013 any Coumadin put on hold per physician order will be highlighted by the nurse receiving the order and the order discontinued to identify that the drug is not to be given and when the drug continued it will be re written on the MAR. Any issue identified will be immediately corrected and both the physician and family notified. All Physicians orders will be reviewed in Daily clinical review Monday-Friday on an ongoing basis and checked against the MAR by Unit Manager to identify any problems with taking physician's orders and posting to the MAR.

A one time random audit of 4 licensed staff giving medicine to 6 patients was completed by the DON/ETD/UM to identify any issue with medication order, transcription to the MAR, medication administration and that the eight rights of medication pass was followed. This was completed on 7/25/2013 and no issues were identified.

A one time audit of the medication carts on all units was completed by the UM to identify any medication in the cart that was d/c' d, any medication stored improperly and to identify any medication ordered that was not in the cart. This was completed on 7/22/2013 and no issues were identified.

3. The Education and Training Director (ETD) will re educate all licensed nursing staff and all KMAs (medication aides) regarding following physician order for all medications, following physician orders for obtaining labs, transcribing medications per physician orders and procedure to obtain labs per physicians order, the eight rights of medication pass, what drugs require a level, what is a medication error and how to correctly discontinue any medication. This will be completed by 7/9/2013. The NC re educated the DON, UM, ADON and ETD on 6/13/2013 regarding procedure to follow up on every physician order, eight rights of medication pass, what to notify physician about, what drugs require levels and procedure to discontinue Coumadin and re write order to ensure that all staff giving medications know when Coumadin or any drug is not to be given.

Beginning 6/27/2013 all change in Coumadin orders will be brought to the Interdisciplinary meeting 5 x week to verify that order is followed and that Coumadin is on the MAR correctly.

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Pg 8

Beginning the week of 6/20/2013 the NC will audit all Coumadin orders 2 x monthly x 3 months to ensure all Coumadin orders are transcribed correctly, all PT/INR orders are followed and that all changes are brought to the IDT meeting.

Beginning week of 7/9/2013 the DON or the NC will audit at least 15 physicians orders weekly x 4 weeks then 10 random orders weekly x 4 weeks to ensure that all orders are followed per physician orders and that UM is validating the orders per this plan. Beginning the week of 07/08/13- UM and/or ETD will monitor 2 licensed staff members administering medication to ensure policy is being followed weekly for 4 weeks.

Beginning the week of 7/9/2013 the UM and/or DON will audit 15 records x 4 weeks to ensure all leveled drugs have orders for labs to monitor and that they are obtained per physicians order and that labs on the draw list are completed per order.

Beginning the week of 7/9/2013 the UM, DON will review 10 residents' physician orders looking back 30 days weekly for 4 weeks to ensure all orders are on the MAR correctly and that all drugs are in the medication cart with the correct directions for administration.

Pharmacy consultant to monitor medication pass to at least 3 patients monthly beginning 7/2013. Any issues will be reported to physician and family.

UM to audit at least one medication cart weekly x 4 weeks beginning week of 7/24/2013 to ensure all medications ordered are in the cart and available, that no medication that has been dc'd is on the cart and that all medications are stored correctly.

4. The QA Committee consisting of at least Administrator, DON, UM, ADON, Medical Director, Social Services, ETD and Activities Department will meet monthly beginning 7/2013 to review audit findings, make recommendations and review this plan. This process will be on going until this issue is considered resolved.

5. Date of Compliance 7/25/2013.