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

PRINTED: 05/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. BUILDING _____ B. WING _____	C 04/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER - HY-PANA ACCEPTED 6/29/15 CH	4545 SHELLEY COURT STOCKTON, CA 95207

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during the investigation of complaint #CA00432722. Representing the Department of Public Health: Pharmaceutical Consultant II 1480/15338 Pharmaceutical Consultant II 2010/23013 Pharmaceutical Consultant II 2183/26819 Nursing Consultant III, Infection Prevention and Control 2745/33399 The investigation was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	Golden Living Center - Hypana submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Redd | TITLE: Executive Director | (X6) DATE: 5/26/15

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 425	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review, the facility failed to ensure a supply of an approved emergency medication, Lorazepam oral concentrate (liquid anti-anxiety medication), was readily available in the automated emergency medication supply (EMC) cabinet, in accordance with facility policy, with the potential for a delay in treatment. Findings: The inspection of the secured refrigerated EMC cabinet on the South Station with the Director of Nursing Services (DNS) on 2/25/15, at 11 a.m., included various prescription medications stored on parallel shelving in unsealed numbered multi-compartment plastic boxes 1 - 26. Closer inspection of Bin 10 included the box section designated for two bottles of Lorazepam oral concentrate 2 mg/mL (milligrams per milliliter) 30 mL (milliliters) was empty. During a concurrent interview, the DNS confirmed the emergency supply of Lorazepam oral concentrate was not present. Review of the current EMC inventory report, dated 2/25/15 and provided by PharmTech, confirmed Bin 10 indicated zero "on hand Qty [quantity]" of Lorazepam oral concentrate 2 mg/mL 30mL. Review of the facility's approved "EMC Formulary" list indicated Lorazepam oral concentrate was listed.	F 425	**F 425 483.60 (a) , (b) PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RHP** **1.** • There were no residents affected by the deficient practice. **2.** • Residents needing Lorazepam from the EMC had the potential to be affected. There were no residents identified as needing Lorazepam and not having it on hand. **3.** • Pharmacy staff was in-serviced by pharmacy manager on replenishing emergency items within 72 hours of being used. Any changes to par level for a formulary item will be approved by the pharmacy committee prior to implementation of those changes. **4.** • Pharmacy will audit the inventory in the EMC 2x's per week to ensure that quantity in the inventory reflects the quantity in the formulary. Audit will be given to DNS or designee.	

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F 425	Continued From page 2 During an interview on 2/25/15 at 1 p.m. the Administrator (ADM) provided "Pharmacy Sub-Committee Minutes of Meetings" indicating the EMC medication supply contents was approved on 8/15/14. Review of the facility policy 3.5 Emergency Pharmacy Service and Emergency Medicine Cabinet, undated, indicated: "K. The Quality Assessment and Performance Improvement Committee in consultant with the pharmacy is responsible for establishing the list of medications to be maintained in the emergency supply..." The policy further indicated: "I. The EMC is monitored electronically allowing the pharmacy to remotely verify stock levels in the EMC and determine when restocking is required." During a telephone interview on 2/25/15 at 1:58 p.m., RPh 1 was unable to explain why the approved inventory of Lorazepam oral concentrate 2 mg/mL was not present in the EMC. RPh 1 stated par levels varied among facilities serviced by the contracted provider pharmacy. Review of the E-Kit Dispense report, dated 2/27/15 and provided by the Pharmacy Manager (PM), indicated a 30mL bottle of Lorazepam oral concentrate 2 mg/mL was removed by licensed staff for a resident on 1/1/15; the contracted provider pharmacy did not restock the device with a replacement bottle until 2/26/15 (56 days later). During an interview on 2/27/15 at 12:05 p.m. PM confirmed the findings.	F 425	• DNS or designee will bring trends to QAPI Q 3 month and will re-evaluate need to continue monitoring. 5. • To be completed by 5/29/2015	
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=E	Continued From page 3 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and	F 431	F431 483.60 (b), (d), (e) DRUG RECORDS, LABELS/STORE DRUGS & BIOLOGICALS 1. • There were no residents affected by the deficient practice. 2. • All residents have the potential to be affected with the same deficient practice. 3. • Key to the ADU room was changed on 2/22/2015 and only licensed nurses have access to the ADU/EMC room. • When ADU/EMC items were delivered and were locked up at in the medication room effective 2/26/2015. • Going forward effective 5/22/2015 they are being locked up in the ADU/EMC room only licensed nurses have access to this room. 4. • Pharmacy technician will be provided a list of items being sent to the facility which she/he will use to cross reference delivered medications in the building. Any discrepancies will be reported to the pharmacist and DNS/or designee immediately.	

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F 431	Continued From page 4 facility document review, the facility failed to ensure secure storage and ongoing control of refrigerated emergency medication cabinet (EMC) supplies of Lorazepam oral concentrate liquid and injectable (anti-anxiety Schedule IV controlled drugs); and control and accountability for contracted pharmacy provider deliveries of automated dispensing unit (ADU) and EMC cabinet replacement medications, in accordance with facility policy, with the potential for medication theft. Findings: 1a. Inspection of the secured refrigerated EMC cabinet on the South Station with the Director of Nursing Services (DNS) on 2/25/15, at 11 a.m., included various prescription medications stored on parallel shelving in unsealed numbered multi-compartment plastic boxes (1 - 26). Closer inspection of Bin 10 indicated the box section designated for two 30 mL bottle of Lorazepam oral concentrate 2 mg/mL was empty and Bin 12 (labeled to contain four vials) contained two vials of Lorazepam 2 mg/mL for injection. During a concurrent interview, the DNS confirmed the supplies of Lorazepam were accessible to licensed nurses who withdrew any emergency medication from the refrigerator; and that no routine reconciliation process was conducted by licensed nurses. The DNS indicated the provider pharmacy maintained electronic records of medication withdrawals (those electronically scanned on removal from the EMC). During an interview on 2/25/15 at 11:30 a.m., the PharmTech, who indicated he worked for the contracted provider pharmacy, stated he reconciled EMC controlled drug counts (including	F 431	• Pharmacy tech will conduct random spot checks 2'sx per week to ensure that controlled substances are in their own locked containers. Non compliance issues identified will be corrected immediately and will be reported to pharmacist and to the DNS/or designee. • DNS/or designee will monitor during routine rounds to ensure that deliveries from pharmacy are locked up in the med room. • Pharmacy technician to provide list of items delivered to the facility to DNS/or designee including any discrepancies found • All findings will be reviewed during the Department Managers meeting. • DNS or designee will bring trends to QAPI Q 3 month and will re-evaluate need to continue monitoring. 5. • To be completed by 5/29/2015	

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F 431	Continued From page 5 the Lorazepam) once a month. During an interview on 2/25/15 at 1:58 p.m., the Pharmacist in Charge (RPh 1) confirmed pharmacy technicians conducted a monthly EMC controlled drug inventory; if empty medication bins were observed, the technician would investigate. Review of the facility policy 4.2 Controlled Substance Storage, dated May 2012, indicated under item E: "If the seal has been broken to the emergency narcotic supply, then a physical count of the contents must be conducted by two licensed nurses..." 1b. Inspection of the multi-use utility room housing the ADU and EMC on 2/25/15 at 11 a.m. included two stacked cardboard boxes (sealed with tamper-evident tape and labeled with the provider pharmacy's name) had been placed on the counter adjacent to the device. During an interview on 2/25/15 at 11:30 a.m., the PharmTech indicated he was in the facility almost daily (Monday through Friday) and on call during the weekends; and his responsibilities included loading medications (including controlled drugs) from the cardboard boxes into the EMC and ADU. During an interview on 2/25/15 at 1:38 p.m., RPh 1 indicated the contracted provider pharmacy arranged delivery of boxed ADU and EMC medications (which included controlled drugs) to the facility. RPh 1 indicated licensed nurses then placed the boxes in the room with the ADU/EMC until the pharmacy technician arrived to place the medications in the device.	F 431		

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F 431	Continued From page 6 On 2/27/15 at 10:50 a.m., the administrator (ADM) confirmed both licensed nursing and non-licensed staff had access to the multi-use utility room housing the ADU and EMC; and a key to unlock the door was observed hanging on a hook on the upper left corner of the door. Review of the facility policy 4.1 Storage of Medications, dated May 2012, indicated under item B: "Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications...permitted to access medications ...medication supplies are locked when not attended by persons with authorized access." On 2/27/15 at approximately 11 a.m., the the Pharmacy Manager (PM) stated the provider pharmacy delivered (via courier) boxes of ADU and EMC medications (sealed with tamper-evident tape) to the facility in plastic sealed totes; licensed nurses placed the sealed totes in the medication room until the pharmacy technician arrived to stock the device. Concurrent observation of the medication room indicated a box (not a sealed tote) had been placed within and contained an affixed sticker: "Attention Nurse: Do NOT open this box hold in ADU room for [name of pharmacy] service tech." During an interview on 2/27/15 at 11:30 a.m. with PM, when asked about the sticker directing nursing staff to place boxes containing ADU and EMC replacement inventory "in the ADU room" and referencing the 2/25/15 observation of cardboard boxes on the counter in the utility room, PM indicated boxes of medications may have been placed in the ADU room where non-licensed staff had access, should have been	F 431		

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F 431	Continued From page 7 placed in the locked medication room, where only licensed nursing staff had access. During an interview on 2/27/15 at 11:45 a.m. PharmTech confirmed each cardboard box of ADU and EMC replacement inventory contained a list of the box contents. PharmTech indicated he did not anticipate how many boxes had been shipped by the pharmacy; and did not reconcile the number of boxes with the pharmacy's delivery manifest. During an interview on 2/27/15 at 11:55 a.m., when asked regarding the accountability of the current system of tracking of boxes containing ADU and EMC inventory from the pharmacy, PM indicated another state was piloting a bar code system that would track every package "real time."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 8 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and document reviews, the facility failed to establish and maintain an Infection Control Program that provided a safe and sanitary environment that prevented the transmission of pathogens (germs) and infection when: 1. The medical waste container used to contain blood products and body fluids, capable of transmitting infectious agents was located in a clean area of the medication/utility room within three feet of the automated medication dispensing unit and medication preparation area. 2. The medication/utility room was cleaned once per day instead of after each laboratory specimen	F 441	**F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **F 441 Infection Control, Prevent Spread, Linens** **1.** • The medical waste container used to contain blood products and body fluids, capable of transmitting infectious agent that was located in a clean area of the medication/utility room within three feet of the automated medication dispensing unit and medication preparation area was removed by the Housekeeping and Laundry Supervisor on 2/18/15 and relocated in the other utility room. The room was cleaned and disinfected on 2/18/15 by the Housekeeping Supervisor. • The medication/utility room that was cleaned once per day instead of after each laboratory specimen processing procedure of blood testing, and blood, stool, urine, specimen handling was cleaned and disinfected by the Housekeeping Supervisor on 2/18/15 using the 3M Quat Disinfectant.	

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F 441	Continued From page 9 processing procedure of blood testing, and blood, stool, urine specimen handling. 3. The FDA registered disinfection product was not used in accordance with manufacturer's recommendations. Therefore, the disinfection product used for the medication/utility room, where blood specimens were processed was not effective for blood borne pathogens such as hepatitis B, C and human immunodeficiency viruses. Findings: 1. On 2/27/15 during intermittent observations of the utility room, the medicalwaste container was observed to be within 3 feet of a clean medication preparation area. According to the Centers for Disease Prevention and Control (CDC) medications should be drawn up in a designated clean medication area that is not adjacent to areas where potentially contaminated items are placed. Examples of contaminated items that should not be placed in or near the medication preparation area include: used equipment such as syringes, needles, IV tubing, blood collection tubes, needle holders, or other soiled equipment or materials that have been used in a procedure. In general, any item that could have come in contact with blood or body fluids should not be in the medication preparation area. During an interview with the facility's Infection Control Preventionist (ICP) on 2/27/15 at 11:20 am, she acknowledged that due to the possibility of cross contamination of the clean medication preparation area, the location of the medical	F 441	The Laboratory was notified by the Executive Director on 2/18/15 to inform them to follow their own cleaning policy for the centrifuge. The Lab provided a cleaning log and available for review by the Infection Preventionist for compliance and for the surveyors. • The Centrifuge was removed from the building on 2/26/2015 2. • All residents have the potential to be affected with the same deficient practice. The issue was corrected on 2/18/15 and no other utility rooms were identified with the same deficient practice. • The FDA registered disinfection product was changed to 3M Quat Disinfectant to ensure it's effective for blood borne pathogens such as hepatitis B, C and human immunodeficiency viruses. No other residents were identified by this deficient practice.	

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F 441	Continued From page 10 waste container was not suitable for the staff to access for the purpose of disposal of supplies contaminated with blood and body fluids. 2. During interviews with the Environmental Services Supervisor (ESS) and the ICP on 2/27/15 at 11:30 a.m., the ESS stated the utility room was on her daily (once per day) cleaning schedule. She stated if a spill of blood occurred on the countertop in between her daily cleaning, the staff would clean the spill with a paper towel then notify her for a follow-up cleaning. According to the CDC, work surfaces that become contaminated with blood or other body fluids can expose [individuals] to a bloodborne disease through cross-contamination (The spread of germs from one surface to another by contact); and [it is necessary to] promptly clean and decontaminate spills of blood or other potentially infectious materials. There was no policy or procedure available at the time of survey that described the daily routine cleaning process of the medication/utility room that included the decontamination of work surfaces. Upon further interview, with the ESS and the Infection Control Preventionist (ICP) on 2/27/15 at 11:30 a.m., they acknowledged that no cleaning or disinfectant products were available in the utility room for the use of facility staff. 3. During an interview with the ESS, on 2/17/15 at 11:30 a.m., she presented the cleaning product that was used for her daily cleaning of the utility room [Trademark] Quat Disinfectant Cleaner Concentrate (Product No. 5, Twist 'n Fill System). When asked how she would apply the product for	F 441	3. • Training and education was give to nursing staff by the Infection Preventionist on 2/27/2015 regarding the relocation of the medical waste container from the ADU/utility room to another utility room (Dirty section) and in addition, staff were in-serviced on infection control related to the medical waste container in the ADU room being capable of transmitting infectious agents. 4. • Infection Preventionist will monitor facility compliance by checking the medication/utility room at least five times a week during her infection prevention and control rounds, non compliance issue identified will be corrected immediately and report will be submitted during the Department managers meeting to the DON and/or Executive Director for review, validation and immediate resolution.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. BUILDING _____ B. WING _____	C 04/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER - HY-PANA	4545 SHELLEY COURT STOCKTON, CA 95207

(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 441	Continued From page 11 a blood spill on the counter of the utility room, she replied that she would clean and disinfect with the [Trademark] product and a cloth and let the surface remain wet for 3 minutes. According to the manufacturer's recommendations for Quat Disinfectant Cleaner Concentrate 5: Leave surface wet for 1 minute for HIV (human immunodeficiency virus, the virus that causes AIDS) and 10 minutes for HBV (hepatitis B) and HCV (Hepatitis C) with use solution. According to the CDC: select EPA-registered disinfectants ... and use them in accordance with the manufacturer's instructions;...promptly clean and decontaminate spills of blood or other potentially infectious materials; follow proper procedures for decontamination of spills of blood or blood-containing body fluids. On 2/17/15 at 12:10 p.m. the employee file for ESS was requested from Administrator (ADM). There was no documentation of education and training for the use of disinfectants in the file. A record of "Chemicals: Use and Dilution," training dated 1/20/2015, for the environmental services staff was presented that was taught by the ESS. The training outline did not include instruction on the use of [Trademark] Quat Disinfectant Cleaner Concentrate.	F 441	• DSD will ensure facility compliance by checking weekly that the housekeeping staff uses the EPA - registered disinfectants and use them in accordance with the manufacturer's instruction, non compliance issues identified will be corrected immediately and will report to the DON and Administrator for immediate resolution and validation. • DSD/Infection Preventionist will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations x's 3 months or until resolved. **5. To be completed by 5/29/2015**	

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A 000	HSC Section 1261 The following represents the findings of the California Department of Public Health during the investigation of complaint #CA00432722. Representing the Department of Public Health: Pharmaceutical Consultant II 1480/15338 Pharmaceutical Consultant II 2010/23013 Pharmaceutical Consultant II 2183/26819 Nursing Consultant III, Infection Prevention and Control 2745/33389 The investigation was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	A 000	Golden Living Center - Hypana submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.	
A 014	HSC 1261.6(b) HSC Section 1261 (b) Transaction information shall be made readily available in a written format for review and inspection by individuals authorized by law. These records shall be maintained in the facility for a minimum of three years. This Statute is not met as evidenced by: Based on observations, staff interviews and facility document review, the facility failed to ensure automated dispensing unit (ADU) and emergency medication supply (EMC) cabinet transaction reports were readily available for inspection by State Agency surveyors. Findings: Inspection of the secured refrigerated EMC cabinet on the South Station with the Director of Nursing Services (DNS) on 2/25/15, at 11 a.m., indicated various prescription medications stored on parallel shelving in unsealed numbered	A 014		

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A 014	Continued From page 1. multi-compartment plastic boxes 1 - 26. Closer inspection of Bin 10 indicated the box section designated for two bottles of Lorazepam oral concentrate 2 mg/mL (milligrams per milliliter) 30 mL (milliliters) was empty. During a concurrent interview, the DNS confirmed the emergency supply of Lorazepam oral concentrate was not present. When asked for an electronic transaction report specifying when the product was removed, the DNS stated she did not have access to reports indicating EMC use at the facility. The DNS indicated the contracted provider pharmacy maintained electronic records of medication withdrawals. During an interview on 2/25/15 at approximately 1 p.m., the administrator (ADM) confirmed that no ADU or EMC transaction reports were readily available at the facility, only at the provider pharmacy, and the pharmacy electronically mailed transaction reports to the DNS on a daily basis. During a follow-up interview on 2/27/15 at 12 noon ADM stated she also received ADU and EMC transaction reports from the pharmacy via electronic mail; but had deleted the reports from her email. Admin confirmed no ADU or EMC transaction reports were available for inspection at the facility.	A 014	**A014 HSC 1261.6 (B) HSC SECTION 1261** 1. • DNS was in-serviced on 5/21/15 by ED to print and retain electronic transaction reports . 2. • All residents who have received medications from the ADU/EMC have the potential to be affected with the same deficient practice. No other residents were identified as having the potential to be affected by the deficient practice. 3. • DNS was in-serviced on 5/22/15 to print and retain electronic transaction reports. • DNS/or designee will print electronic transactions reports specifying when the product was removed and place in a binder and retain for 3 years. • ED will spot check binder weekly for compliance. 4. • Findings of spot checks will be brought to QAPI monthly x's 3 month or until resolved. 5. • To be completed by 5/29/2015	
A 021	HSC 1261.6(f) HSC Section 1261 (f) When used to provide pharmacy services pursuant to Section 4119.1 of the Business and Professions Code, the automated drug delivery system shall be subject to all of the following requirements: (1) Drugs removed from the automated drug	A 021		

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A 021	Continued From page 2 delivery system for administration to a patient shall be in properly labeled units of administration containers or packages. (2) A pharmacist shall review and approve all orders prior to a drug being removed from the automated drug delivery system for administration to a patient. The pharmacist shall review the prescriber's order and the patient's profile for potential contraindications and adverse drug reactions. (3) The pharmacy providing services to the facility pursuant to Section 4119.1 of the Business and Professions Code shall control access to the drugs stored in the automated drug delivery system. (4) Access to the automated drug delivery system shall be controlled and tracked using an identification or password system or biosensor. (5) The automated drug delivery system shall make a complete and accurate record of all transactions that will include all users accessing the system and all drugs added to, or removed from, the system. (6) After the pharmacist reviews the prescriber's order, access by licensed personnel to the automated drug delivery system shall be limited only to drugs ordered by the prescriber and reviewed by the pharmacist and that are specific to the patient. When the prescriber's order requires a dosage variation of the same drug, licensed personnel shall have access to the drug ordered for that scheduled time of administration. (7) (A) Systems that allow licensed personnel to have access to multiple drugs and are not patient specific in their design, shall be allowed under this subdivision if those systems have electronic and mechanical safeguards in place to ensure that the drugs delivered to the patient are specific	A 021	**A021 HSC 1261.6 (f) HSC Section 1261** 1. • All emergency medication supply will be placed into separate closed units within the ADU/EMC by 5/29/2015. 2. • All residents who have received medications from the ADU/EMC have the potential to be affected with the same deficient practice. The issue will be corrected by 5/29/2015 and no other ADU/EMC machines are in facility 3. • The emergency drug supplies not in the locked lidded portion of the ADU/EMC will be stored in portable containers which are sealed in such a manner that the tamper proof seal must be broken to gain access to the drug in accordance with Section 72377 of Title 22 by 5/29/2015. These kits may be stocked in the ADU/EMC but will comply with the requirements of Section 72377 of Title 22. • In-service to be completed with licensed staff by DSD to educate on compliance with Title 22 emergency medication storage by 5/29/2015.	

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A 021	Continued From page 3 to that patient. Each facility using such an automated drug system shall notify the department in writing prior to the utilization of the system. The notification submitted to the department pursuant to this paragraph shall include, but is not limited to, information regarding system design, personnel with system access, and policies and procedures covering staff training, storage, and security, and the facility's administration of these types of systems. (B) As part of its routine oversight of these facilities, the department shall review a facility's medication training, storage, and security, and its administration procedures related to its use of an automated drug delivery system to ensure that adequate staff training and safeguards are in place to make sure that the drugs delivered are appropriate for the patient. If the department determines that a facility is not in compliance with this section, the department may revoke its authorization to use automated drug delivery systems granted under subparagraph (A). (C) This paragraph shall remain in effect only until January 1, 2012, unless a later enacted statute is enacted on or before January 1, 2012, deletes or extends that date. This Statute is not met as evidenced by: Based on observations, staff interviews and facility document review the emergency medication supply (EMC) cabinet had an open matrix configuration and therefore licensed nurses had access to multiple non-patient specific medications; not in compliance with current regulatory requirements. Findings: Inspection of the secured EMC cabinet on the South Station with the Director of Nursing	A 021	• Spot checks to be completed by DNS or designee 5x's per week to ensure that emergency medication supplies are kept in locked units. 4. • Findings from spot checks completed 5 x's per week will be reported to QAPI Q month for 3 months or until resolved. 5 • To be completed by 5/29/2015	

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A 021	Continued From page 4 Services (DNS) on 2/25/15, at 11 a.m., included the top compartment (upper door) contained 44 prescription medications stored on parallel shelving in unsealed numbered multi-compartment plastic boxes numbered 1 through 48; the (middle door) refrigerator compartment contained 21 prescription medications stored on parallel shelving in unsealed numbered multi-compartment plastic boxes numbered 1 through 26; and the bottom compartment (Drawer 7) contained 28 slots storing prescription medications. All three storage areas indicated an open matrix configuration, meaning licensed nurses had access to multiple non-patient specific medications. During an interview on 2/27/15 at 12:50 p.m., the pharmacy manager (PM) acknowledged the upper cabinet, refrigerator and bottom drawer EMC medications were stored in an open matrix configuration. PM indicated the pharmacy had limited each EMC open matrix inventory area (the upper and middle drawers and Drawer 7) to no more than 48 medications and 16 doses.	A 021		