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

PRINTED: 06/19/2017
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
	056189	A. BUILDING _____ B. WING _____	C 06/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VISTA TRANSITIONAL CARE CENTER	3033 AUGUSTA ST SAN LUIS OBISPO, CA 93401

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health, Licensing and Certification, during a Standard Abbreviated Survey. Entity Reported Incident (ERI) CA00537116 - Substantiated Representing the Department: 33720 - HFEN The inspection was limited to the investigation of the ERI and does not reflect the findings of a full inspection of the facility.	F 000	Bella Vista Transitional Care Center (hereafter, "Bella Vista") makes its best effort to operate in full compliance with both Federal and State law and any applicable standard of practice. Nothing included in this Plan of Correction is an admission to guilt but is submitted in order to comply with its regulatory obligation to the basis, merits, and/or form of any obligation contained herein. This Plan of Correction submitted by Bella Vista is our Allegation of Compliance. **F-431 – Labeling and Storage of Biologicals** **How Corrective Actions Will Occur for Residents Who Have been Affected by the Deficient Practice**	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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) 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient	F 431	Immediately upon the discovery of the missing narcotics, facility pharmacy Pharmerica was contacted to verify receipt of the medication by the facility and to identify the licensed nurse that signed for them. After confirmation was received by the facility, attending physician was contacted to make him aware of the missing drugs. Physician provided an additional prescription to the local pharmacy and the resident was discharged safely with no missed doses of the medication. The resident was unaffected by the situation. **How the Facility Will Identify Other Residents who have the Potential to be Affected by this Deficient Practice** When the missing narcotics were discovered on May 15th, a sweep was conducted by the Administrator with the licensed nurse present of all six medication carts in the building to ensure that there were no additional missing narcotics. Sweep indicated that all other narcotics delivered to the facility on May 14th were accounted for.	5/15/15, Administrator 5/15/17 Administrator

Not accepted 7/31/17 Joseph

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/30/17

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 431	Continued From page 1 detail to enable an accurate reconcillation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 record review and interview, the facility failed to follow an established system of receiving and storing contolled medication. This failure resulted in the disappearance of a controlled medication.	F 431	All of the other controlled substances that were delivered to the facility on May 14th were accounted for and were kept under standard procedural lock and key. On May 15th, DON conducted interviews with staff involved with the receipt of the narcotics for that day. On May 16th, DON performed a sweep of all med carts, med rooms and resident rooms to attempt to locate the missing narcotics. Additional interviews of staff were conducted. **Measures/Systemic Changes Put Into Place To Ensure that the Deficient Practice Does Not Reoccur** Beginning on May 17th and concluding on May 26th, DON inserviced licensed nurses on the proper storage of controlled substances. Additionally, the document entitled "Notice Regarding Controlled Substances and Narcotics to All Licensed Nurses" was distributed and signed by all licensed nurses. This document details the facility's procedure to follow when receiving a controlled substance from the pharmacy, steps to opening an emergency kit and the facility's practice that prohibits "borrowing" of drugs from another resident's supply. The letter also emphasizes the serious nature of handling these substances and the consequences that follow failure to abide by facility policy and practice. At the facility QA meeting to be held on July 13th, 2017, a new revised policy and procedure will be reviewed with the IDT regarding facility's receiving and storage of controlled substances and narcotics. For all new licensed employees, the "Notice Regarding Controlled Substances and Narcotics.." will be covered during their facility orientation. The facility's new policy and procedure regarding receiving and storage of controlled substances and narcotics will be reviewed during skills check prior to starting of work. Additionally, this policy and procedure will be reviewed annually during skills check.	5/15/17, DON 5/16/17, DON 5/17/17, DON 7/13/17, Administrator and DON Ongoing, DSD and DON

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F 431	Continued From page 2 Findings: The facility policy and procedure entitled "Medication Storage Controlled Medication Storage," dated 08/09, indicated in part, "Medications included in the federal Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations." A review of the facility investigation report/documents, revealed in part, the facility became aware of the 60 missing Norco (a controlled narcotic used to treat moderate to severe pain) tablets on 5/15/17 at 6:20 p.m. The facility searched all the nursing medication carts, the medication rooms and the resident rooms, the medication was not found. Further review of the facility's investigation indicated that a telephone interview with license nurse (LN 1) and the facility administrator took place on 5/15/17, at 6:20 p.m. According to the telephone conversation notes; On 5/14/17, around 7 p.m., LN 1 walked to another nursing station, found LN 2 standing in- front of his medication cart by room 10 and asked if Resident 1 was his patient, LN 2 responded yes to LN 1. LN 1 walked towards LN 2 and told him she had Resident 1's medication (Norco). LN 2 was at his medication cart and was looking through his electronic medical records and responded, "Okay". LN 1 then placed the medication card containing the 60 Norco tablets on top of LN 2's medication cart.	F 431	Pharmacy consultant will include the checking of narcotic counts at her monthly visit to ensure that all narcotics are accounted for. **How the Facility Plans to Monitor Its Performance to Ensure that the Deficient Practice Does Not Reoccur** Pharmacy consultant will place special emphasis on narcotic count verification. Monthly, audits of the facility will be conducted by the pharmacy consultant as well to ensure proper counts. Any deficient practice or discrepancies in narcotic counts will be reported to facility Administrator and DON. Any deficient findings will be brought to the attention of our quarterly QA meetings by the DON.	Ongoing Ongoing

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F 431	Continued From page 3 The facility telephone interview conducted by the administrator with LN 2, on 5/15/17, at 6:35 p.m., revealed, "LN 2 did not have any recollection of what happened. LN 2 did not remember receiving Norco medication from LN 1. He did remember LN 1 approaching him and talking to him briefly, but had no recollection of the details of the event." During an interview with the director of nursing (DON), on 6/13/17, at 9 a.m., handouts from an in-service training for the licensed nurses dated 5/17/17 were reviewed. According to the inservice, "Licensed Nurses receiving medications other than their resident(s) must have the other Licensed nurse sign the copy of receipt verifying receipt of the medications... Licensed Nurses will then place the controlled drug in the narcotic box in the medication cart and securely lock (double locks) immediately upon receipt, as per facility's policy." The DON was asked if this handout was new information or if it is a part of the facility's existing policy and practice at the time of the narcotic loss, the DON stated, "This is not new or unique to this facility. This is a standard of practice, to lock your medications." When asked if this policy was part of the training for new employees, the DON stated, "Yes, we go over this with the director of staff development (DSD) on new employee orientation." During an interview with the facility DSD, on 6/13/17, at 9:30 a.m., the DSD acknowledged as part of her new employee orientation, the DSD goes over the medication and storage process. The DSD stated, "I review this when they (new employees) attend orientation. I tell them that	F 431		

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F 431	Continued From page 4 they need to count the amount and they are responsible for their residents narcotics including locking them up. I go over all of this information in my orientation." A review of the facility employee files indicated both LN 1 and LN 2 had attended and completed new employee orientation prior to the discovery of the missing Norco medication.	F 431		