STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555080	A. BUILDING _____ B. WING _____	C 08/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRACY NURSING AND REHABILITATION CENTER	545 WEST BEVERLY PLACE TRACY, CA 95376

POC accepted 9/19/19

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of facility reported incident #CA00646066. Representing the Department of Public Health: HFEN, 29917 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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.	F 755		9/13/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2019

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 755	Continued From page 1 §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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to establish a system of records to ensure accurate receiving, dispensing, and reconciliation of all controlled drugs, and follow their "Controlled Medication Storage" policy and procedure, for one of three sampled Residents (Resident 1), when a prescription for 60 tablets of acetaminophen/oxycodone (a narcotic pain medication) had two reconciliation sheets for the same prescription. In addition, the facility's practice of multiple people having access to the same medication cart and the facility's system of record keeping failed to show accurate numbers of controlled drugs delivered with the actual numbers on hand. These system failures lacked sufficient accountability detail to enable an accurate reconciliation of narcotics, and potentially contributed to narcotic diversion. Findings: On 7/17/19, at 10 a.m., an onsite visit was conducted at the facility to investigate a facility reported incident involving a bubble pack of acetaminophen/oxycodone found missing from	F 755	Resident 1 received narcotic medication timely as needed without delay and sustained no negative effects. The DON in-serviced licensed nurses regarding narcotic count processes on 7/15/2019. The DON reviewed all residents within the facility prescribed narcotics with no discrepancies found. Installation of two narcotic lock boxes in a single drawer of the middle cart has been installed, in which only the assigned licensed nurse has access corresponding to their specific assignment. All backup keys to medication storage areas including controlled medications are kept by the DON. The pharmacy will label narcotic cards and corresponding count sheet with labels indicating bubble pack 1 of 2 and 2 of 2 and corresponding count sheets labeled 1 of 2 and 2 of 2. An additional narcotic log implemented on 7/31/19 that is signed by two licensed nurses when accepting narcotics from the pharmacy will be monitored biweekly by DON for proper handling and allocation.	

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F 755	Continued From page 2 one of the facility's medication carts. Review of the physician's order, dated 7/11/19, revealed a prescription for Oxycodone/Tylenol 10 milligrams oxycodone with 325 milligrams of acetaminophen, take one tablet by mouth every "4-6 hours" as needed for pain. Review of the pharmacy label revealed the quantity dispensed to the facility was 60 tablets. The prescription was sent in two bubble packs, each bubble pack contained 30 tablets and each bubble pack had its own narcotic count sheet. The missing bubble pack, which contained 30 tablets of the narcotic pain medication for Resident 1 and the corresponding controlled narcotic count sheet was found missing by License Nurse (LN) 1. The drug labels and the delivering pharmacy's Delivery Sheet were inspected, they both indicated that 60 tablets of acetaminophen/oxycodone were initially delivered to the facility on 7/11/19, and signed by LN 1. However, when the facility's Controlled Drug Record was inspected, it only showed 30 tablets of Oxycodone/Tylenol being available, as the other bubble pack and its corresponding controlled drug record count sheet was missing. The system of two narcotic drug record accountability sheets for the same prescription, had the potential to contribute to drug diversion as one entire bubble pack of 30 tablets and its corresponding drug record accountability sheet were missing. The pharmacy label did inform the facility staff the bubble pack being counted was "Card 1 of 2." Review of the facility's "Medication Storage in the Facility" policy effective date August 2014, read in	F 755	The DON will provide any findings in monthly QAPI Committee meetings for three months, and if no findings will resolve as compliance is sustained.	

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F 755	Continued From page 3	F 755		

pertinent part, "...D. At each shift change, a physical inventory of all controlled medications,...is conducted by two licensed nurses and is documented on the controlled medication accountability record."

The facility used three Medication Carts, identified as Cart A, B and "Middle Cart." Each cart is assigned to a medication nurse at the beginning of each shift, and only the assigned nurse receives the key allowing access to the narcotics in the double locked drawer.

During an interview with the Director of Nurses (DON) and the facility Administrator on 7/17/19 at 10:30 a.m, both stated, LN 1 remembered receiving two bubble packs for Resident 1 a few days prior, stated two narcotic count sheets were also delivered (one narcotic count sheet for each of the two bubble packs of oxycodone/acetaminophen received which contained 30 tablets each).

During an interview with the Director of Nursing (DON), conducted on 7/17/19 at 11:10 a.m., the DON stated that besides the Medication Nurse and the Charge Nurse, the two other medication nurses assigned to Med Carts A and B also had access to the Middle Cart's narcotic drawer.

On 7/17/19, at 11:35 a.m., review of the facility's policy on medication storage titled, "Controlled Medication Storage," dated August 2014, indicated, "The access system to controlled medications that are stored under double lock is not the same as the system giving access to other medication....Back up keys to all medication storage areas, including those for controlled medications, are kept by the director of nursing."

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F 755	Continued From page 4 The facility was unable to account for the 30 tablets of oxycodone/acetaminophen or the narcotic count sheet which accompanies the medication.	F 755		