STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675336	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KIRKLAND COURT HEALTH AND REHABILITATION CENTER	**1601 KIRKLAND DR AMARILLO, TX 79106**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review; it was determined the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access for 2 of 4 medication/treatment carts reviewed for medication storage. On 4/26/20, RN A failed to lock the Southeast Hall Treatment Cart containing numerous medications when she left the treatment cart unattended to provide resident care. On 4/26/20, RN A failed to lock the Southeast Hall Treatment Cart containing numerous medications when she left the treatment cart unattended to provide resident care. On 5/4/20, RN A failed to lock the Southeast Hall Treatment Cart containing numerous medications when she left the treatment cart unattended to provide resident care. On 5/4/20, RN A failed to lock the Southwest Hall Treatment Cart containing numerous medications when she left the treatment cart unattended to provide resident care. On 5/4/20, RN A failed to lock the Southwest Hall Medication Cart containing numerous medications when she left the treatment cart unattended to provide resident care. The facility's failure to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access places residents at risk for drug diversion, accidental or intention overdose on medication, accidental ingestion of toxic or caustic substances, and exposure to toxic or caustic substances. Findings include: During an observation on Initial Tour on 4/26/2020 at 8:12 AM, no staff were visible from Southeast Hall. The Southeast Hall Treatment Cart was unlocked and unattended. The Southeast Hall Treatment Cart contained numerous medications including, but not limited to [MEDICATION NAME] powder, [MEDICATION NAME] cream, [MEDICATION NAME] cream and mupirocin ointment. After waiting 2 minutes, facility staff approached. MA B confirmed the treatment cart should not be left unlocked when unattended. MA B confirmed medications were kept in the treatment cart. When asked who left the Southeast Hall Treatment Cart unlocked, MA B denied she left the treatment cart unlocked. When asked who was responsible for the Southeast Treatment Cart, MA B stated, The nurse. During an observation on Initial Tour on 4/26/2020 at 8:20 AM, no staff were visible from Southwest Hall. The Southwest Hall Treatment Cart was unlocked and unattended. The Southwest Hall Treatment Cart contained numerous medications including, but not limited to [MEDICATION NAME] powder, [MEDICATION NAME] cream, [MEDICATION NAME] cream and mupirocin ointment. After waiting 2 minutes, RN A emerged from a Resident's room. RN A confirmed medication/treatment carts should not be left unlocked when unattended. RN A confirmed medications were kept in the treatment cart. When asked who was responsible for the Southwest Hall Treatment Cart, RN A stated, I am. During an observation on 5/4/20 at 10:38 AM, no staff were visible from Southeast Hall. The Southeast Hall Treatment Cart was unlocked and unattended. The Southeast Hall Treatment Cart contained numerous medications including, but not limited to [MEDICATION NAME] powder, [MEDICATION NAME] cream, [MEDICATION NAME] cream and mupirocin ointment. After waiting 1 minute, staff emerged from a Resident's room. During an observation on 5/4/20 at 10:42 AM, no staff were visible from Southwest Hall. The Southwest Hall Treatment Cart was unlocked and unattended. The Southwest Hall Treatment Cart contained numerous medications including, but not limited to [MEDICATION NAME] powder, [MEDICATION NAME] cream, [MEDICATION NAME] cream and mupirocin ointment. The Southwest Hall Medication Cart was unlocked and unattended. The Southwest Hall Medication Cart contained all the medications for all residents on the Southwest Hall. After waiting 1 minute, emerged from a resident's room. RN A confirmed medication/treatment carts should not be left unlocked when unattended. RN A confirmed medications were kept in the treatment cart. When asked who nurse responsible for the treatment and medication carts was, RN A stated, I am. During an interview on 4/26/2020 at 9:05 AM, when asked whether medication/treatment carts were to be left unlocked while unattended, ADM stated, No, never. When asked what the risks of leaving medication/treatment carts unlocks and unattended were, ADM stated, Someone can take the medications. Record Review of the facility's Policy for Storage of Medication, dated 4/23/20, it stated: POLICY: 1. Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. In accordance with State and Federal laws, the facility will store all drugs and biologicals in locked compartments . 2. The medication and biological supply is only accessible to licensed nursing personnel, pharmacy personnel or authorized staff members.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.