STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305078	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARRIS HILL CENTER, GENESIS HEALTHCARE	20 MAITLAND STREET CONCORD, NH 03301

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review and interview, it was determined that the facility failed to ensure an accurate accounting for all controlled medications for 6 residents out of 9 residents reviewed. (Resident identifiers are #1, #2, #3, #4, #6, and #9.) Findings include: Review on 7/28/20 of the facility policy and procedure titled Controlled Drugs: Management of with a revision date of 11/1/19 revealed the following: The management of controlled drugs-including the ordering, receipt, storage, administration, ongoing inventory, and destruction- is conducted under the direction and ultimate responsibility of the Center Executive Director and Center Nurse Executive and follows safe practice and federal/state regulations Ongoing Inventory: A complete count of all Schedule II-Iv controlled drugs is required at the change of shifts per state regulation or any time in which narcotic keys are surrendered from one licensed nursing staff to another, The count must be performed by two licensed nurse .Destruction: two licensed professional are required to destroy and document destruction of controlled drugs. Review on 7/28/20 of the facility policy and procedure titled Medication Administration: General with a revision date of 11/1/19 revealed the following: 11. Document: 11.1 Administration of medication on Medication Administration Record (MAR) Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing. 7th ed. St. Louis, Missouri: Mosby Elsevier, 2009. Page 709: After administering the medication, indicate which medications were given on the client's MAR per agency policy to verify that the medication was given as ordered. Record medication administration as soon as medications are given to client Page 688 Guidelines for Safe Narcotic Administration and Control . Store all narcotics in a locked, secure cabinet or container. . Narcotics are frequently counted. Usually counts are made on a continuous basis with the opening of narcotic drawers and/or at shift change. . Report discrepancies in narcotic counts immediately. . Use a special inventory record each time a narcotic is dispensed. Records are often kept electronically and provide an accurate ongoing count of narcotics dispensed. Records are often kept electronically and provide an accurate ongoing count of narcotics used and remaining as well as information about narcotics that are wasted. . Use the record to document the client's name, date, time of medication administration, name of medication, dose, and signature of nurse dispensing the medication. . If a nurse gives only part of a premeasured dose of a controlled substance, a second nurse witnesses disposal of the unused portion. If paper records are kept, both nurses sign their names on the form. Computerized systems record the nurses' names electronically. Do not place wasted portions in the sharps containers. Instead, flush wasted portions of the tablets down the toilet and wash liquids down the sink. Resident #1 Review on 7/28/20 at approximately 11:00 a.m. of Resident # 1's EMAR (Electronic Medication Administration Record) for May 2020 revealed a physician's orders [REDACTED].) for [MEDICATION NAME]-[MEDICATION NAME] tablet 5-325 mg (milligram) 1 tablet by mouth every 6 hours as needed for moderate pain. On the EMAR it was documented that the medication was given to Resident #1 on 5/12/20, 5/19/20, 5/30/20, and 5/31/20. Review of the facility's narcotic book page #85 for May 2020 revealed that the medication was signed out of the narcotic book 53 times between 5/6-5/31/20. Resident #2 Review on 7/28/20 at approximately 11:00 a.m. of Resident #2's EMAR for May 2020 revealed a P.O. for [MEDICATION NAME] HCl tablet 5 mg 1 tablet by mouth every 4 hours as needed for pain. On Resident #2's EMAR it was documented that Resident #2 received the medication on 5/29/20, 5/30/20, and 5/31/20. Review of the narcotic book (no page number) revealed that the medication was signed out 13 times between 5/28-5/31/20. On 5/31/20 the medication is noted to have been wasted twice with no second signature. Resident #3 Review on 7/28/20 at approximately 11:00 a.m. of Resident #3's EMAR for May revealed a P.O. for [MEDICATION NAME] HCl tablet 50 mg tablet 2 tablets by mouth every 6 hours as needed for pain. On Resident #3's EMAR it was documented that Resident #3 received the medication on 5/19/20. Review of the narcotic book page #39 revealed that the medication was signed out 47 times between 5/6-5/31/2020. Resident #4 Review on 7/28/20 at approximately 11:00 a.m. of Resident #4's EMAR for May revealed a P.O. for [MEDICATION NAME] HCl tablet 5 mg 2 tablets by mouth every 4 hours as needed for pain. On Resident #4's EMAR it was documented that Resident #4 received the medication on 5/1/20, 5/3/20, 5/5/20, 5/6/20, and 5/12/20. Review of the narcotic book page #144 revealed that the medication was signed out 30 times between 5/1-5/12/20. Resident #6 Review on 7/28/20 at approximately 11:00 a.m. of Resident #6's EMAR for May revealed a P.O. for [MEDICATION NAME] 15 mg 1 tablet by mouth every 4 hours as needed for pain. On Resident #6's EMAR it was documented that Resident #6 received the medication on 5/1/20 and 5/3/20. Review of the narcotic book page #65 and 48 revealed that the medication was signed out 18 times between 5/1-5/4/20. Resident #9 Review on 7/28/20 at approximately 11:00 a.m. of Resident #9's EMAR for May revealed a P.O. for [MEDICATION NAME] HCl tablet 2 mg give 3 tablets by mouth as needed for wound care up to twice daily. On Resident #9's EMAR it was documented that Resident #9 received the medication on 5/12/20, 5/15/20, 5/16/20, 5/19/20, and 5/27-5/29/20. Review of the narcotic book page 92 revealed that the medication was signed out 37 times between 5/3-5/30/20. On 5/14/20, 5/16/20, 5/18/20, and 5/25/20 the medication was signed off as being given 3 times when the P.O. was written to be given up to twice daily, and on 5/20/20 the medication was signed off as being given 4 times. Interview on 7/28/20 at approximately 12:00 p.m. with Staff A (Administrator) and Staff B (Director of Nursing) confirmed the above findings. Staff A and Staff B confirmed re-education for all nurses in the facility was completed in proper narcotic count procedures and documentation as well as detection of drug diversion. Staff B also confirmed that the pharmacy was called to perform an audit of narcotic counts and medication administration records and this was completed. Going forward, Staff B will be completing weekly audits and will be submitting the findings to the quality assurance program. Review on 7/28/20 at approximately 11:45 a.m. of the weekly audits begining 6/2/20 of the EMAR and nacrotic books revealed that all nacrotics and EMAR were reconciled correctly. Review on 7/29/20 at approximately 12:30 p.m. of the education provided to the licensed personnel between 6/5-6/15/20 revealed it included the following: Narcotic Count Procedure, Detection of Drug Diversion in a Long Term Care Facility, Detecting Diverion, and review of F602, F608 and F755. This education was completed on 6/15/20. Telephone interview on 7/29/20 at approximately 12:15 p.m. with Staff D (Advance Practice Registered Nurse) revealed that Staff C had requested a refill for pain medication for Resident #1. Staff D interviewed Resident #1 and Resident #1 did not have any pain to report. Staff D reviewed the EMAR for Resident #1 which did not have any prn narcotic medications or pain medications administrated. Staff D then reviewed the narcotic book and narcotics had been taken out every day by Staff C as often as allowable per the prn order. At the time of the review by Staff D, Staff D spoke with Staff C who indicated Staff C did not have enough time to fill out the EMAR. After this conversation, Staff D reported the incident to the Staff A and did not refill the narcotic in question.

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.