STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675967	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHGATE PLAZA	**2101 NORTHGATE DR IRVING, TX 75062**

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 -** Few	**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, the facility failed to store all drugs and biologicals in locked compartments and to permit only authorized personnel to have access for one (designated COVID-19 unit) of four halls observed. The facility failed to ensure all medications were stored properly on the designated COVID-19 unit (hall 100). These failures could affect residents by placing them at risk of ingesting unprescribed medications which could lead to adverse effects. Findings included: Observation on 05/28/20 at 4:15 PM revealed overflow medications stored in Resident #1's room (118) in an unlocked four-compartment dresser in the bottom two drawers. Overflow medications were also stored in Resident #1's unlocked closet. The medications found were prescription medications including [MEDICATION NAME], [MEDICATION NAME], and Antibiotic. Interview on 05/28/20 at 4:18 PM with CNA A revealed Resident #1's room used to be their supply room, but the facility asked the staff members to place Resident #1 in that room. CNA A explained Resident #1 was only ambulatory in her wheelchair and she could not self-transfer. CNA A said Resident #1 did not like to get into her wheelchair and stayed in her bed all day. Interview on 05/28/20 at 4:30 PM with LVN A revealed there was a locked medication cart on the designated COVID-19 unit but there was not enough space to store the overflow medications on the locked medication cart. LVN A said there were no narcotics stored in Resident #1's room, just overflow medications. The medications belonged to the residents on the designated COVID-19 unit. Interview on 05/28/20 at 6:00 PM with the Administrator revealed staff should have moved the medications into the locked medication cart or notified the Administrator or DON that there was not a safe place to store those medications. Interview on 05/29/20 at 10:29 AM with the DON revealed the medications in Resident #1's room were all overflow and there were no narcotics. The DON stated some medications were discontinued because of discharged residents. The DON explained the medications found in Resident #1's room on the designated COVID-19 unit were [MEDICATION NAME], [MEDICATION NAME], and Antibiotics. The DON said the medications should have been taken to the barrel for drug destruction, placed on the locked medication cart, or placed in the locked medication storage room. Record Review of the facility's policy for Storage of Medications, dated April 2007, reflected: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only in the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. .7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual, cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly. 10. Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys.

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