STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056086	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LA MARIPOSA CARE AND REHABILITATION CENTER	**1244 TRAVIS BLVD FAIRFIELD, CA 94533**

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 -** Few	**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 interview and record review, the facility failed to maintain an effective system for monitoring and accounting for the disposition of controlled drugs when nurses failed to perform the narcotic count for one medication cart at change of shift. This failure resulted in a narcotic count discrepancy when 17 doses of Resident 1's [MEDICATION NAME]/[MEDICATION NAME] (a narcotic pain medication, brand name [MEDICATION NAME]) had gone missing and could not be found. This failure had the potential to leave Resident 1 with untreated pain when all of her remaining doses of [MEDICATION NAME] were gone from the medication cart. Findings: On 1/28/20 the Department received an anonymous complaint that during the nurses' narcotic count, 17 doses of a narcotic were discovered missing, and the previous shift had failed to do the narcotic count at change of shift. During an inspection of the Hall 1 medication cart on 2/7/20 at 11:57 a.m., Licensed Nurse A described how the nurses did the narcotic count at change of shift. Licensed Nurse A stated they counted the number of cards in the narcotic box, then they documented the number of cards on a log, and then both nurses initialed the log. Licensed Nurse A stated the nurses then verified the count of each narcotic against the count sheets, but this verification was not documented. During an inspection of the Hall 3 medication cart on 2/7/20 at 12:45 p.m., Licensed Nurse B confirmed the process of the narcotic count she followed at change of shift was the same process as Licensed Nurse A. During an interview on 2/7/20 at 1:09 p.m., Licensed Nurse C stated she had heard about a discrepancy with the narcotic count. The medication that had gone missing belonged to Resident 1. She stated Licensed Nurse B may know about it. She could not recall when exactly it happened, but remembered it was Licensed Nurse D's first day back from leave. During an interview on 2/7/20 at 1:15 p.m., Licensed Nurse B stated she had been working night shift when the narcotic discrepancy was found. She stated there were three medication carts and the Hall 2 cart was shared by the two nurses who were working that night. When the PM shift nurse left for the night, Licensed Nurse B had not done the count on the Hall 2 cart because she had thought the other two nurses had done the count. The other two nurses thought she had done the count. It was a miscommunication. When the AM shift nurses came on, it was discovered during the narcotic count that Resident 1's card of [MEDICATION NAME] was missing from the Hall 2 cart. Licensed Nurse B was Resident 1's nurse, but Resident 1 had never asked for pain medication while she was caring for her. Resident 1 only had that one card of [MEDICATION NAME], which had some pills popped out. During a record review on 2/7/20 at 1:20 p.m., review of the licensed staff schedule revealed Licensed Nurse D's first day back from leave was 1/7/20. Licensed Nurse D worked PM shift that day (3 p.m. to 11 p.m.). Review of Resident 1's medical record revealed she was admitted [DATE] and discharged [DATE]. Resident 1's admit orders included [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg (milligrams, a unit of measure) every four hours as needed for breakthrough pain. During an interview on 3/4/20 at 11:37 a.m., DON stated she looked everywhere for five days for the missing [MEDICATION NAME]. It was never found. She stated her expectation was for the count of the Hall 2 medication cart to be done by the nurses who finished report first. During an interview on 3/5/20 at 8:07 a.m., Licensed Nurse E stated that the day the [MEDICATION NAME] went missing, she was doing the count at the end of her shift with the AM shift nurse. The count sheet for Resident 1's [MEDICATION NAME] was in the book but the card of [MEDICATION NAME] was not in the narcotic box. She stated, We looked in the cart three times, but it was not there. We looked in the other two carts, we looked in the residents' rooms, it was not there. Licensed Nurse E stated she did not do the count at the beginning of her shift because she thought she saw the other nurses do it, so she thought it was done. During an interview on 3/5/20 at 1:20 p.m., Licensed Nurse D stated it was her first day back from leave when the narcotics went missing. She was working on Hall 1 and split Hall 2 with the other nurse. She gave report to the night shift and counted the narcotics on the Hall 1 cart. She had seen the other PM shift nurse leave already, so she thought he must have counted the Hall 2 cart. Licensed Nurse D stated, I admit we didn't count. Review of Resident 1's document titled Record of Controlled Substances (the count sheet) revealed the nurses' documentation of the [MEDICATION NAME] doses removed from Resident 1's card of [MEDICATION NAME] tablets. The count sheet indicated Resident 1's card had originally contained 28 doses of [MEDICATION NAME]. Between 12/24/19 and 1/7/20 eleven doses had been removed, with the last dose removed at 8 a.m. on 1/7/20, leaving 17 doses in the card. Review of Resident 1's pharmacy delivery sheets indicated 28 doses of [MEDICATION NAME] were delivered to the facility on [DATE] and 14 doses were delivered on 1/13/20. Review of facility policy and procedure Controlled Medication Storage, not dated, revealed, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. At each shift change, a physical inventory of all controlled medications shall be conducted by two licensed nurses and is documented on the controlled substances accountability record.

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.