| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | **235026** | A. BUILDING _____ B. WING _____ | **03/05/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **GOGEBIC MEDICAL CARE FACILITY** | **402 NORTH STREET WAKEFIELD, MI 49968** |

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) |
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| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**<br><br>Based on observation, interview and record review, the facility failed to appropriately reconcile controlled substances, and account for all controlled medications, potentially effecting all second floor Residents. This deficient practice resulted in the potential for drug diversion. Findings include: (All times are recorded in Eastern Standard Time.) On 3/04/20 at 8:05 a.m., Licensed Practical Nurse (LPN) C and LPN B were observed counting/reconciling the controlled substances in a second floor medication cart. LPN C did not look at the medication cards in the cart, but rather wrote numbers in a book that LPN B called out, as she flipped through the cards in the medication cart. When asked how she knew first hand that the numbers LPN B called out were actually the accurate number of pills in the card, LPN C said she didn't. Registered Nurse (RN) A was nearby and was asked if she reconciled the controlled substances in the medication cart she was responsible for, and responded she did not. RN A said LPN C and LPN B reconciled both carts then she would take responsibility for her cart, without actually determining first hand that the controlled substances she was responsible for were accurate. All three nurses confirmed they could not verify an accurate controlled substance count, using the manner in which the reconciliation was observed. During an interview on 3/04/20 at 8:31 a.m., the Director of Nursing (DON) and LPN C were present. LPN C said she took over the medication cart on the second floor, from a different nurse at 1:00 p.m., without counting or reconciling the controlled substances in that cart. The DON agreed that controlled substances could not accurately and definitively be accounted for in that manner. The DON stated, I would want to know myself that my med(ication) cart was accurate. I understand. Both nurses confirmed accurate reconciliation of controlled substances needed to happen. The policy Controlled Substances, dated 11/12/15, revealed, .The purpose of this policy is to assure safe and proper disposition of accounting for controlled substances .two nurses together will count the amount of each narcotic in the narcotic cabinet to ensure it matches the amount of drug and number on the Certificate of Disposition form. Medications to be counted for verification include all Scheduled II medications .all controlled medications . |
| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to maintain the integrity of a medication label, to ensure appropriate medication adminstration, for one Resident (#34), and failed to ensure the secure and separate storage of all medications, potentially effecting all 102 Residents. This deficient practice resulted in the potential for drug diversion and the wrong dose to be given and decreased efficacy of treatment for [REDACTED]. Findings include: (All times are recorded in Eastern Standard Time.) During a review of the storage of medications in central supply on [DATE] at 10:10 a.m., various over the counter medications such as pain relievers, anti-heartburn, anti-diarrheals, anti-fever medications, vitamins and minerals, and anti-stomach upset medications were observed stored on open shelves in the room. Staff D was present and said the supply room was accessible to others after hours, including janitors. There was a video camera on the ceiling behind the medication shelves. There was a refrigerator in the room with a dirty bottom shelf and dried various foodstuffs on the shelves lining the door. The refrigerator contained various vaccinations, containers of coffee, Staff D's lunch, as confirmed by Staff D, and other food condiments in the door of the refrigerator. When asked if it was appropriate to store the food stuffs in the same refrigerator as the vaccines, Staff D stated, I don't know. Staff D confirmed there was no process to account for each of the shelved medications and that more was ordered only when the supply was visually low. During an interview on [DATE] at 10:51 a.m., the Director of Central Supply/ Staff E confirmed the camera footage in the supply room was not routinely monitored, and that other staff had access to the room after hours. Staff E confirmed the foodstuffs should not be in the same refrigerator as the vaccines. Staff E also agreed there was potential for staff to enter the supply room and remove a bottle of pain medication for personal use, without discovery. On [DATE] at 11:09 a.m., the first floor south hall medication cart was reviewed with Registered Nurse (RN) F. RN F confirmed a plastic bag of bottled prescribed medications in the bottom compartment of the cart, was for Resident #34, who acquired medications through a different approved source. One of the bottles contained [MEDICATION NAME], a diabetes medication, with a defaced label. The dosage of the pills was unable to be seen by this Surveyor or RN F. The expiration date was barely readable, but was noted to be [DATE]. RN F confirmed she could not make out the dosage of the pills and confirmed the expiration date. RN F also confirmed the pills should not be given, but that Resident #34 was given the pills in the defaced bottle. RN F said ensuring the five rights (safety checks required prior to any medication administration: right resident, right medication, right route, right dose, right time), prior to medication administration was not possible with the defaced label. During an interview on [DATE] at 11:27 a.m., the Director of Nursing (DON) had Resident #34's bottle of [MEDICATION NAME] on her desk and confirmed the label was defaced. The DON could not discern the dosage of the pills, and confirmed the bottle was expired. The policy Medication Storage, dated [DATE], was absent any information regarding the security of medication storage, medication labels, and the separation of medications from food storage. |

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