

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 2, 3, 4, & 5, 2013</p> <p>Facility number: 000144 Provider number: 155240 AIM number: 100266760</p> <p>Survey team: Cheryl Mabry, RN-TC Diana McDonald, RN Angela Patterson, RN Melissa Gillis, RN</p> <p>Census bed type: SNF/NF: 54 Total: 54</p> <p>Census payor type: Medicare: 7 Medicaid: 35 Other: 12 Total: 54</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 14, 2013; by Kimberly Perigo, RN.</p>	F000000		
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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.

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F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interview, and record review, the facility failed to meet professional standards as indicated by their policy and procedures in that a nurse administered a pain medication that she had not removed from the medication cart and prepared for administration to a resident. (RN #1) (LPN #1) (Resident #31)</p> <p>Findings include:</p> <p>On 12/5/13 at 1:10 p.m., Resident # 31 was observed in bed complaining of pain. Resident #31 was encouraged to call the nurse. RN #1 entered the room and asked resident what [gender] needed. Resident #31 indicated, "I hurt all over." RN #1 indicated, "I will get you a Tylenol, is that ok?" RN # 1 was then observed to open the medication cart on the 100 hall, take out a white pill, and place the pill into a pill cup. RN #1 was then observed talking with LPN #1. RN #1 gave the pill cup and cup of water to LPN #1. LPN #1 was observed to enter Resident #31's room, LPN #1 asked Resident #31 if</p>	F000281	<p>1. Residents #31 received her Tylenol during the survey process and experienced pain relief.RN#1 and LPN#1 received education regarding the policy and procedures for administration of medication2.All current residents are receiving medications per policy and procedure in that the nurse who administers the medication is the nurse who removes the medication from the cart.3. The systemic change will include: Licensed nurses and QMAs will complete a competency check for medication administration with emphasis on following policy and procedure for administration of medication only by the nurse or QMA that pulls the medication from the cart. This competency check will continue for any newly hired nurses or QMAs and at least annually.Education will be provided to licensed nurses and QMAs regarding following policy and procedure for administration of medication only by the nurse or QMA that pulls the medication from the cart.4. The Director of Nursing or designee will audit a medication pass daily, on random shifts, including weekends, 5 times a week for 4 weeks, then weekly for 4 weeks, then every</p>	01/03/2014

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	<p>[gender] was hurting and had Resident #31 rate pain on 1-10 scale. Resident #31 indicated pain was a "10." LPN #1 indicated, I will call the doctor. LPN #1 proceeded to give the white pill, given to her by RN #1, to Resident #1 and left the room.</p> <p>Interview with the DON on 12/5/13 at 1:35 p.m., when asked about standard nursing practice for administering medications indicated, "The nurses are to make sure right medication, right route, right resident, right dose, and right time." When asked if nurses are to administer medication they haven't prepared for administration themselves indicated, "No, they are only to administer medication that they pop out. No nurse should give a medication that they didn't pull."</p> <p>Interview with LPN #1 on 12/5/13 at 1:43 p.m., when asked what was standard nursing practice for administering medication indicated, "Right medication, right route, right resident, right dose, and right time." When asked if she had done that with Resident #31 indicated, "No, I'm not going to lie." When asked how do you know what the medication was LPN#1 indicated, "I don't know." When asked if you should give</p>		<p>other week for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly for the duration of 12 months. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p>		

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	<p>medication you did not prepare for administration yourself, she indicated, "No, but I did." When asked why RN#1 did not administer the pill she prepared for administration from the medication cart, she indicated, "I don't know, she asked me if I wanted to give."</p> <p>Interview with RN #1 on 12/5/13 at 1:50 p.m., when asked why she didn't give the pill to Resident #31 since she prepared the pill for administration RN#1 indicated, "Because [gender] nurse (LPN #1) returned." When asked if that was standard nursing practice RN#1 indicated, "No."</p> <p>On 12/5/13 at 1:29 p.m., the DON (Director of Nursing) provided the Medication Administration: General Policy & Procedures, undated and indicated, the policy was the one currently used by this facility. Review of the policy indicated, "... 2. Only the licensed nurse or approved designee who prepares the medication may administer it. a) That same nurse or designee is then responsible for recording its administration in the resident 's MAR at the time it is given ..."</p> <p>3.1-35(g)(1)</p>				

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure that nursing staff performed proper handwashing during meal service, as indicated by the facility policy. This had the potential to affect 31 out of 31 residents who were served in the main dining room. (CNA #1, CNA #3, Restorative Aide #1, and DON).</p> <p>Findings include:</p> <p>1. Observation of the main dining hall on 12/2/2013 at 12:00 p.m., indicated Restorative Aide #1 served 12 residents in the main dining hall without proper handwashing, as indicated by facility policy. Restorative Aide #1 served Resident #59 and Resident #78 drinks and used hand sanitizer. She then went to another table and served Resident #77 and Resident #42 drinks and then proceeded to wash her hands. Restorative Aide #1 used soap and water, but only washed her hands for</p>	F000371	<p>1.C.N.A. #1, C.N.A. #3, Restorative Aide #1 and the DON were offered education regarding washing of hands as indicated by facility policy.2.Nursing staff is performing proper hand washing during meal service, as indicated by facility policy.3.The systemic change will include:Nursing staff who serve in the dining room will complete a competency check for hand-washing.In addition, this competency will be completed upon hire and annually.Education will be provided to nursing staff regarding the facility policy and procedure for proper hand washing during meal service.4. The Staff Development Coordinator or designee will monitor proper hand washing during meal service 5 times a week, at random meals and on weekends.These audits will continue for 4 weeks, then one time a week for 4 weeks over random meals, including weekends, then monthly thereafter for a duration of 12 months of monitoring.Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility</p>	01/03/2014	

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	<p>10 seconds. She then proceeded to serve Resident #30, Resident #60, Resident #62, Resident #76, and Resident #63 drinks. She then went to the kitchen door, rang the door bell, and spoke with a kitchen employee. She then used hand sanitizer, from one of her front pockets, as she walked back to the tables. She served Resident #64, Resident #14, and Resident #43 drinks. She then used hand sanitizer again.</p> <p>2. On 12/2/2013 at 12:11 p.m., an observation of the Restorative Aide #1 in the main dining room during meal service indicated, she washed her hands for five seconds. At that time an observation of the DON indicated, she turned off the water with her wet hands, after washing her hands for 20 seconds, and before obtaining paper towel. She then served a resident their tray.</p> <p>On 12/2/3013 at 12:17 p.m., observation of CNA #3 in the main dining room during meal service indicated she washed her hands for 10 seconds. At that time Restorative Aide #1 washed her hands for 10 seconds. At that time CNA #1 was observed to wash hands for 10 seconds, turned off the water with wet hands, and then obtained a paper</p>		Quality Assurance Committee meeting monthly for 3 months and then quarterly for one year. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.				

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	<p>towel to dry hands. At that time an interview with CNA #1 indicated, she knew to wash hands for 20 seconds.</p> <p>On 12/3/2013 at 12:06 p.m., observation of the Restorative Aide #1 in the main dining room during meal service indicated, she washed her hands for 15 seconds. At that time an interview with Restorative Aide #1 indicated, the amount of time for hand washing was 30 seconds.</p> <p>Observation of the main dining hall on 12/2/2013 at 12:00 p.m., indicated Restorative Aide #1 served 12 residents in the main dining hall without proper handwashing, as indicated by facility policy. Restorative Aide #1 served Resident #59 and Resident #78 drinks and used hand sanitizer. She then went to another table and served Resident #77 and Resident #42 drinks and then proceeded to wash her hands. Restorative Aide #1 used soap and water, but only washed her hands for 10 seconds. She then proceeded to serve Resident #30, Resident #60, Resident #62, Resident #76, and Resident # 63 drinks. She then went to the kitchen door, rang the door bell, and spoke with a kitchen employee. She then used hand sanitizer from one of her front pockets as she</p>						

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	<p>walked back to the tables. She served Resident #64, Resident #14, and Resident #43 drinks. She then used hand sanitizer again.</p> <p>On 12/3/2013 at 9:58 a.m., the Assistant Director of Nursing provided the facility's "Handwashing/Hand Hygiene" policy, revised October 2013, and indicated the policy was the one currently used by the facility. Review of the policy indicated, "Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections...</p> <p>2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors...</p> <p>5. Employees must wash their hands for 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:</p> <p>a. Before and after direct contact with residents...</p> <p>When to Use Alcohol-Based Hand Rub</p> <p>6....use an alcohol-based rub containing 60-95% ethanol...for all the following situations:</p> <p>a. Before and after direct contact with residents..."</p>						

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	3.1-21(i)(3)				

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F000425 SS=B	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services that ensured medications were accurately dispensed to meet the needs of 2 residents who received narcotic medications and ensured discontinued medications were disposed as indicated by facility policy. (Resident #61, #20)</p> <p>Findings include:</p> <p>1.) Observation on 12/4/2013 at 2:45 p.m., RN#1 and LPN#2 were performing a narcotic count for the</p>	F000425	<p>1. Residents #61 and #20's guaifenesin with codeine was disposed of during the survey process per facility policy 2. All carts were audited during the survey process for timely disposal of narcotic medications when discontinued per facility policy.No other concerns were noted.3.The systemic change includes:All orders for medications will be reviewed at the morning clinical meeting (Monday through Friday).Any narcotic medication that is to be discontinued will be tracked at this meeting for timely removal from the medication cart and destruction.Consulting pharmacy services will audit all</p>	01/03/2014	

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	<p>300 hall odd side room's medication cart. When RN #1 examined a bottle of guaifenesin/codeine (Each 5 ml (1 teaspoonful) contains: 100 mg guaifenesin, which temporarily controls cough due to minor throat and bronchial irritation as may occur with the common cold, 10 mg codeine phosphate a narcotic which has a warning that it may be habit forming, and 3.5 percent alcohol.) for Resident #20. RN#1 displayed the bottle, which contained between 80 ml and 85 ml based on the markings on the side of the bottle. LPN #2 indicated the bottle should contain 118 ml, based on the Controlled Drug Record. LPN #2 indicated no one had documented administrating any does of guaifenesin/codeine to Resident #20 and LPN #2 indicated there was a problem with documentation and took the narcotic documentation sheet to the DON.</p> <p>2.) Observation on 12/4/2013 at 2:45 p.m., LPN #3 and LPN #4 were performing a narcotic count for the 200 hall medication cart #2. When LPN #3 examined a bottle of guaifenesin/codeine (Each 5 ml (1 teaspoonful) contains: 100 mg guaifenesin, which temporarily controls cough due to minor throat and bronchial irritation as may occur with the common cold, 10 mg codeine</p>		<p>medication carts quarterly for presence of expired medication per facility policy. The facility has started a "Cart Captain" program, in which a nursing administrative person is in charge of auditing all medication carts on a monthly basis for presence of expired medication. Education will be provided to licensed nurses, pharmacy consulting services and QMAs regarding the systemic change. 4. The Unit Manager or designee will audit all narcotic medications stored on the medication carts for medications that require disposal due to expiration or discontinued daily, Monday through Friday, for 4 weeks, then weekly for 4 weeks, then monthly for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly for one year. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p>		

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	<p>phosphate a narcotic which has a warning that it may be habit forming, and 3.5 percent Alcohol.) for Resident #61. LPN #3 displayed the bottle, which contained between 80 ml and 85 ml based on the markings on the side of the bottle. LPN #3 indicated the bottle should contain 118 ml based on the Controlled Drug Record. LPN#3 indicated no one had documented administrating any doses of guaifenesin/codeine to Resident #61 on the Controlled Drug Record. LPN #4 indicated there was a problem with documentation and would inform the DON. Interview with ADON on 12/5/13 at 1:44 p.m., indicate guaifenesin/codeine for Resident #20 medication was started on 7/29/13 and discontinued 14 day after the medication was first administrated, and guaifenesin/codeine for Resident #61 was started on 7/27/2013 and discontinued 7 days after the medication was first administrated. Record review on 12/5/2013/ at 4:15 p.m., of physician's orders for Resident #20 indicated guaifenesin/codeine was ordered on 7/29/2013 and discontinued on 8/12/2013. Record review on 12/5/2013 at 4:20 p.m., of physician's orders for Resident #61 indicated</p>						

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	<p>guaifenesin/codeine was ordered on 7/27/2013 and discontinued on 8/2/2013.</p> <p>Record review on 12/5/2013 at 1:15 p.m., of the Skilled Care Pharmacy Customer Visit Report indicated the Drug Storage Audit "comments: All carts were free of dc'd [discontinued] and/or expired meds. All carts were free debris and/or spillage"</p> <p>On 12/5/2013 at 2:00 p.m., the DON provided Consultant Pharmacy Services Procedure policy, undated, and indicated the policy was current. Review of the policy, indicated, "...11. Review medication-related documentation for accuracy and consistency. 18. Specific responsibilities of the consultant pharmacist are: a.) Conduct a Medication Regimen Review (MRR) of each resident at least once each month and report in writing any potential irregularities and/or comments to the Director of Nursing Services and individual resident's physician. The recommendations MUST be addressed and appropriate action taken in a reasonable time frame.... d.) Audit medication storage areas monthly and medication carts quarterly for proper storage and labeling, cleanliness and presence of expired medications.... h.) May review Medication administration Record</p>						

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	(MARs), and physician orders monthly to ensure proper documentation of medication orders..." 3.1-25(e)(3)			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on interview, observation, and record review, the facility failed to accurately reconcile and account for</p>	F000431	1. Resident #61 and #20's narcotic count was reconciled during the survey process. An investigation was initiated and the missing dosages were accounted	01/03/2014			

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	<p>all controlled medications in 2 out of 6 medication carts. (Resident #61, Resident #20)</p> <p>Findings include:</p> <p>1.) Observation on 12/4/2013 at 2:45 p.m., RN #1 and LPN #2 were performing a narcotic count for the 300 hall odd side room's medication cart #2. When RN #1 examined a bottle of guaifenesin/codeine (Each 5 ml (1 teaspoonful) contains: 100 mg guaifenesin, which temporarily controls cough due to minor throat and bronchial irritation as may occur with the common cold, 10 mg codeine phosphate a narcotic which has a warning that it may be habit forming, and 3.5 percent alcohol.) for Resident #20. RN #1 displayed the bottle which contained between 80 ml and 85 ml based on the markings on the side of the bottle. LPN #2 indicated the bottle should contain 118 ml. LPN#2 Indicated no one had documented administrating any does of guaifenesin/codeine to Resident #20 and LPN #2 indicated there was a problem with documentation and took the Controlled Drug Record for Resident #20 to the DON. Interview on 12/5/2013 at 10:25 a.m., the DON indicated she did not know why the nurses had not documented</p>		<p>for. Pharmacy was notified of the discrepancy. 2. All medication carts were audited during the survey process for accuracy of count of controlled medications and no other concerns were found. 3. The systemic change includes: A competency check has been completed for all current licensed nurses regarding the proper procedure for accounting for controlled medications. This competency check will be continued upon hire and annually. All licensed nurses have been required to sign a statement of understanding and accountability for controlled medication reconciliation and accounting for controlled medications. All newly hired nurses will also have this statement reviewed and signed for acknowledgement of understanding. This includes the need to notify the DON immediately if any discrepancies are noted in the count. The facility has started a "Cart Captain" program, in which a nursing administrative person is in charge of auditing all medication carts on a monthly basis for accuracy of the controlled medication counts. Education has been provided to licensed nurses regarding the proper policy and procedure for accuracy of count of controlled medications and the systemic changes. 4. The Director of Nursing or designee will audit</p>		

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	<p>on the "Controlled Drug Record-Chart each dose administered" of Resident #20 for guaifenesin/codeine medication.</p> <p>Record review 12/5/2013 at 4:15 p.m., of physician order for guaifenesin/codeine for Resident #20 dated 7/29/2013 indicated 10 ml per dose.</p> <p>Record review 12/5/2013 at 12:10 p.m., of PRN MEDICATION ADMINISTRATION MONITORING FORM dated 8/2013 indicate Resident #20 received one, 10 ml or 2 teaspoonful dose of guaifenesin/codeine on 8/1/2013 at 2200 hours.</p> <p>Record review on 12/5/2013 at 12:15 p.m., of drug return for Credit/Disposition Form dated 12/4/2013, indicated 93 ml of guaifenesin/codeine for Resident #20 was discontinued and then destroyed by facility nursing staff.</p> <p>2.) Observation on 12/4/2013 at 2:45 p.m., LPN #3 and LPN #4 were performing a narcotic count for the 200 hall medication cart #2. When LPN #3 examined a bottle of guaifenesin/codeine (Each 5 ml (1 teaspoonful) contains: 100 mg guaifenesin, which temporarily controls cough due to minor throat and bronchial irritation as may occur with the common cold, 10 mg codeine</p>		<p>the accuracy of the count of controlled medications in the medication carts 5 days a week for 4 weeks, then weekly for 4 weeks, then monthly for a duration of 12 months of monitoring. In addition, the shift to shift narcotic count will be monitored by an administrative nurse, 5 days a week on random shifts, including weekends for 4 weeks, then weekly on random shifts, including weekends, for 4 weeks, then monthly on random shifts for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly for one year. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p>				

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	<p>phosphate a narcotic which has a warning that it may be habit forming, and 3.5 percent alcohol.) for Resident #61. LPN #3 displayed the bottle, which contained between 80 ml and 85 ml based on the markings on the side of the bottle. LPN#3 indicated the bottle should contain 118 ml based on the Controlled Drug Record. LPN #3 indicated no one had documented administrating any doses of guaifenesin/codeine to Resident #61 on the Controlled Drug Record. LPN #4 indicated there was a problem with documentation and would inform the DON.</p> <p>Record review on 12/5/2013 at 145 p.m., of physician order dated 7/27/2013 Resident #61 indicated guaifenesin/codeine one teaspoonful every day p.r.n. (as needed) for cough for 1 week.</p> <p>Record review on 12/5/2013 at 10:30 a.m., of "Controlled Drug Record-Chart each dose administered." indicated no dose administration of guaifenesin/codeine for Resident #61.</p> <p>Record review on 12/5/2013 at 10:35 a.m., of facility medication record for p.r.n. medications, 2 doses each day of guaifenesin/codeine for July 29, 30, 31 for Resident #61.</p> <p>Record review on 12/5/2013 at 10:50 a.m., of facility medication records for</p>			

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	<p>September/2013, October/2013, and November/2013 indicated guaifenesin/codeine for Resident #61 was listed as a p.r.n. medication but no doses were administered during the months of September, October, and November.</p> <p>Record review on 12/5/2013 at 3:00 p.m. of Controlled Substances policy received from the DON on 12/5/2013 at 12:45 p.m., indicated "...8.) Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.</p> <p>9.)The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties.</p> <p>10.) The Director of Nursing Services shall consult with the provider pharmacy and the Administrator to determine whether any further legal action is indicated." Policy dated, 2001 MED-PASS, Inc.(Revised April 2007).</p> <p>3.) Observation on 12/5/2013 at 12:50 p.m., LPN #4 and DON were performing a narcotic count for the 100 hall medication cart #2 from a</p>			

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	<p>locked medication box. When LPN #4 counted the number of 5-325mg hydrocodone-acetaminophen tablets (is a narcotic and analgesic combination used to relieve moderate to moderately severe pain.) LPN#4 counted 8 tablets in the medication card and the "Controlled Drug Record-Chart each dose administered" document showed 9 doses available.</p> <p>Interview on 12/5/2013 at 12:55 p.m., LPN #4 indicated, "I screwed up, I gave the pill this morning and I forgot to sign it out."</p> <p>3.1-25(m)</p>			