

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2012	
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241			
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F0000	<p>This visit was for Investigation of Complaint IN00115340.</p> <p>Complaint IN00115340 Substantiated. Federal/State deficiencies related to the allegations are cited at F224, F226 and F431.</p> <p>Survey dates: September 24 & 25, 2012</p> <p>Facility number: 000385 Provider number: 15E667 AIM number: 100291340</p> <p>Survey team: Mary Jane G. Fischer RN</p> <p>Census bed type: NF: 38 Total: 38</p> <p>Census payor type: Medicaid: 38 Total: 38</p> <p>Sample: 4</p>			F0000	<p>Preparation and execution of this plan of correction does not constitute an admission to or an agreement by the provider with the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhurst Healthcare asserts that it is and was in substantial compliance with the regulations governing the operation of long term care facilities; that this Plan of Correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for procedural processing purposes to comply with federal and state regulations and to correlate with the most recent contemplated or accomplished corrective action. These do not necessarily chronologically correspond to the date that Lynhurst Healthcare is under the opinion that it was in participation or that corrective</p>		

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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	<p>Supplemental Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 9/28/12 Cathy Emswiller RN</p>		action was necessary.		

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F0224 SS=E	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, record review and interview the facility failed to ensure misappropriation of resident property did not occur, in that when the facility had residents who had physician orders for controlled pain medication, the nursing staff and pharmacy failed to perform random reconciliation of the medications, which led to a determination of drug diversion for 3 of 4 residents [Residents "A", "C" and "D"] and 9 of 9 supplemental sampled residents reviewed. [Residents "E", "F", "G" "H", "I", "J", "K", "L" and "M"].</p> <p>Findings include:</p> <p>1. Interview on 09-24-12 at 8:40 a.m., the Director of Nurses indicated staff from the Attorney Generals office had been "in and</p>	F0224	<p>1) F0224 What action(s) will be accomplished for those residents found to have been affected? Any resident has the potential to be affected by this deficiency. No resident of this facility was noted or reported to have any ill effect regarding this complaint. On 9-06-2012, controlled medication sheets were found to be absent, by the Director of Nursing. The facility immediately contacted all parties required by regulations, including an ISDH report and IMPD. (IE: "turned itself in"), while this complaint survey occurred on 9/24 and 9/25, 2012. Once the facility was made aware of the possibility/allegations of an issue with medications, the facility immediately contacted all parties required by regulations, including an ISDH report. Drug test were completed on those staff, in the time frame that was indicated, who had contact with the medication carts. The facility policy is that any staff may be drug tested at random any time and should a positive drug test result, or should an employee refuse a drug test, the employee</p>	10/25/2012			

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	<p>out of the facility for the past few weeks investigating drug diversion," which involved at least 3 residents and possibly 4 staff members [employees Registered Nurses employees #3 and #4 and Qualified Medications Aides employees #8 and #9]. "What was happening was the nurses were not turning in the controlled sheets to me, so I wasn't aware of what was going on. After I spoke with [name of Qualified Medication Aide employee #8] I started to look at it."</p> <p>Continued interview on 09-24-12 at 9:00 a.m., the Administrator indicated all nursing staff who worked during a specific time frame had been determined, and were sent for "drug tests." The Administrator indicated Registered Nurse employee #3 tested positive, while Registered Nurse employee #4 refused the testing. Registered Nurse employee #4 was terminated on 09-09-12 and Registered Nurse</p>		<p>will be terminated. As a result of those drug tests, three staff members were terminated immediately. (The facility now drug tests any new hire nurses and QMA.) (see exhibit 'I') The alleged drug diversion remains under the scrutiny of the Attorney General's Office Drug Diversion Unit, this facility, our contracted pharmacy and the IMPD. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Any resident has the potential to be affected by this deficiency. The facility maintains that it does indeed take many varied steps to ensure that misappropriation of resident's property does not occur. (see policies , exhibit A, #'s 1 and 2) The facility's policies and procedures have always been in place and are updated frequently. Our staff is also in-serviced on facility policy and procedures as per regulations of the state and extensively beyond those regulations. The facility includes 8 video surveillance cameras (now 10 cameras, as of 10/2/2012) in it's ongoing efforts to secure the building and to ensure that misappropriation does not occur. All medication and treatment carts are also stored under surveillance cameras. In our humble opinion, the facility nursing staff did not fail to perform random</p>				

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	<p>employee #3 was terminated on 09-10-12. Testing on Qualified Medication Aide employee #9 also tested positive and was terminated on 09-24-12, while Qualified Medication Aide employee #8 tested negative for drugs.</p> <p>Interview on 09-24-12 at 2:50 p.m., Qualified Medication Aide employee #6 indicated she showed the Director of Nurses a copy of the electronic medication administration record for Resident "C" which indicated by her initials that she dispensed Oxycodone 5/325 mg [milligrams] [a controlled pain medication] to Resident "C", while the Controlled drug sheet clearly showed the medications had been "signed out" by Registered Nurse employee #3. "[Name of Registered Nurse employee #3] came and got the keys to the controlled drugs a lot, if [Registered Nurse employee #3] felt the residents needed the prn [as needed medications], [Registered Nurse employee #3] passed them,</p>		<p>reconciliation of the medications. Each licensed nurse and QMA (Qualified Medication Aide) goes through an orientation process, once hired by the facility, to ensure that rules and regulations of the medication pass (but not limited to the medication pass) are explained and followed. Licenses and certifications are checked for validity and any litigation that is available on the "search and verify" state internet site. The facility is contracted with a pharmacy who provides scheduled audits of all medication carts. These audits take place on a scheduled basis. The results of these audits are then given to the Director of Nursing who follows up on any possible issues. The State of Indiana determined it is appropriate to issue nursing licensures and (Certified) Qualified Medication Aide certificates to those who qualify: and the facility relies on those employees who have been issued such documents by the state, to have the full training and the understanding of their scope of practices regarding medication pass/administration rules and regulations, prior to being hired by this facility. However, the facility's policies and procedures are in place and are updated frequently; our staff is also in-serviced on facility policy and procedures as per regulations of the state and beyond. (see attached) By virtue of a</p>				

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	<p>under my initials. [Name of Resident "C"] would hardly take routine medications, it was a struggle, let alone the Oxycodone." When further interviewed the Qualified Medication Aide employee #6 indicated with the electronic medication record system, if she had to leave the cart unattended, she would close the lid of the computer. "Now I know we're suppose to log out so no one can document under my password." When interviewed if there were any complaints from the resident's about the pain medications, the Qualified Medication aide indicated "No, because most of the resident's don't know or understand the types of medications that are ordered due to their diagnoses."</p> <p>2. The record for Resident "C" was reviewed on 09-24-12 at 1:00 p.m. Diagnoses included but were not limited to affective psychosis, bipolar disorder, alcohol abuse, cerebral palsy and hypertension. These diagnoses remained current</p>		<p>Registered Nursing licensure, a Licensed Practical Nurse licensure and/or a certificate for a Qualified Medication Aide ,(recognized by the Sate of Indiana) and by facility policy, these employees may administer and sign off for narcotic medications. The facility requires two licensed staff or a licensed nurse and a Qualified Medication Aide, to sign off on all medications and to take additional precautionary measures with the narcotic count (s). (see attached policies-exhibits A #2 and exhibit B) At this time the facility has put additional measures into place for narcotic counts. (Beginning 9-14-2012) A sheet has been added to show the number of bubble packs (medication containers/narcotic card count sheet) that are present on the cart. This sheet also accounts for all bubble packs that are newly delivered or removed from the cart. (see attached exhibit 'C') Un-announced narcotic reconciliation counts are done on a weekly basis by the Director of Nursing, the Executive Director or the Assistant Director of Nursing. During these reconciliation counts, the narcotics, the narcotic sign in and sign off sheets are also monitored. The Director of Nursing or her designee is also closely monitoring the Daily Activity Medication Log (see</p>	

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	<p>at the time of the record review.</p> <p>The resident had a physician order, dated 07-11-12 for Oxycodone-Apap 5/325 mg [milligrams] by mouth every 6 hours as needed for pain.</p> <p>The resident's current plan of care, originally dated 02-06-12 indicated the resident had "actual complaints of pain to left lower leg," and a subsequent plan of care dated 02-09-12 for "headaches on occasion."</p> <p>Review of the electronic medication administration record indicated the resident received the medication on the following dates: August [2012] 1st at 17:12 [5:12 p.m.], August 2nd at 21:46 [9:46 p.m.], August 8th at 15:16 [3:16 p.m.] and 21:39 [9:39 p.m.], August 9th 05:01 [5:01 a.m.], August 11th 08:31 [8:31 a.m.] and 20:53 [8:53 p.m.], August 18 th 19:34 [7:34 p.m.], August 20th 22:03 [10:03 p.m.], August 23rd 18:17 [6:17</p>		<p>attached exhibit 'J') as it is provided to her by the pharmacy. Un-scheduled narcotic counts are also being done on a weekly basis by the DON, ADON or LHFA (LPN). Once per week the DON or ADON will approach the night/day shift nurse to reconcile the daily delivered medication manifests. (see exhibits B, C , D and exhibit A #2) Pharmacy has been contacted and continues to work with the facility to improve our medications passes and to ensure misappropriation/allegations of, do not occur. Pharmacy has also agreed to send a nurse auditor to our facility once a month for the next three months; these audits will include direct narcotic reconciliation.</p> <p>Continuation of monthly audits after the three month period will be accomplished by a pharmacy technician and the aforementioned changes regarding auditing, by the facility management staff. 3) What measures will be put into place or what systemic changes will be made ? At this time the facility has included additional measures for narcotic counts. (Beginning 9-14-2012) A sheet has been added to the medication count to show the number of bubble packs (medication containers/narcotic card count sheet) that are present on the cart. This sheet also accounts for all bubble packs that are</p>		

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	<p>p.m.], August 27th 10:08 [10:08 a.m.] and 22:01 [10:01 p.m.], and August 31st 09:21 [09:21 a.m.] 11:12 [11:12 a.m.] and 17:27 [5:27 p.m.] - 15 occasions.</p> <p>Review of the handwritten "Controlled Drug Record - Individual Patient's Narcotic Record" indicated the resident received the medication as follows: August 5th at 3:00 a.m., 9:00 a.m. and 3:00 p.m., August 6th at 2:00 a.m., 10:30 a.m., 4:30 p.m., 10:30 p.m., August 7th at 4:30 a.m., 3:30 p.m., and 9:30 p.m., August 8th at 3:00 p.m., and 9:30 p.m., August 9th at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 8:00 p.m., August 10th at 3:00 a.m., August 11th at 8:00 a.m., 2:00 p.m., and 8:00 p.m., August 12 at 3:00 a.m., 10:00 a.m., and 4:00 p.m., August 13th 12:00 a.m., 6:00 a.m., 2:00 p.m., August 14th at 2:00 p.m., August 15th at 6:30 a.m., August 16th at 8:00 a.m., and 2:00 p.m. - 30 occasions.</p> <p>The facility was unable to provide</p>		<p>newly delivered or removed from the cart. (see attached exhibit 'C') Un-announced narcotic reconciliation counts are done on a weekly basis by the Director of Nursing, the Executive Director or the Assistant Director of Nursing. During these reconciliation counts, the narcotics, the narcotic sign in and sign off sheets are also monitored. The Director of Nursing or her designee is also closely monitoring the Daily Activity Medication Log (see exhibit 'J') as it is provided to her by the pharmacy. Un-scheduled narcotic counts are also being done on a weekly basis by the DON, ADON or LHFA (LPN). Once per week the DON or ADON will approach the night/day shift nurse to reconcile the daily delivered medication manifests. Pharmacy was contacted prior to this complaint survey, and continues to work with the facility to improve our medications passes and to ensure misappropriation/allegations of, do not occur. Pharmacy is scheduled at this time to complete cart audits of both medication carts, on a monthly basis; including narcotic reconciliation. Pharmacy has also agreed to send a nurse auditor to our facility once a month for the next three months. Continuation of monthly audits after the three month period will be accomplished by a pharmacy</p>	

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	<p>the "Controlled Drug Record - Individual Patient's Narcotic Record," for the remainder of August 2012. Interview with the Director of Nurses on 09-24-12 at 9:00 a.m., indicated "that was part of the problem, the Controlled Drug Records are missing."</p> <p>Review of the electronic medication administration record for September 1, 2012 thru September 10, 2012 indicated the resident received the medication on 9 occasions, however the "Controlled Drug Record - Individual Patient's Narcotic Record" for the same time period could not be located by facility staff, and a new "Controlled Drug Record - Individual Patient's Narcotic Record," was started for the resident on 09-10-12 which indicated the resident received the medication on 09-12-12 at 5:30 p.m., 09-13-12 at 8:30 p.m., 09-16-12 at 9:00 p.m., and 09-17-12 at 7:00 p.m.</p>		<p>technician and the aforementioned changes regarding auditing, by the facility management staff. The facility includes 8 video surveillance cameras (now 10 cameras, as of 10/2/2012) in it's ongoing efforts to secure the building and to ensure that misappropriation does not occur. QMA #6 has been given written council for not signing off on the EZ Mar Medication Pass system when not in direct use and allowing another employee to pass medications under her electronic signature.(see attached) QMA#6 has been re-educated on the basics of the EZ Mar Medication Pass system, including the "LOCK" button on the computer that allows the staff to close out their computer when not in use. This "LOCK" button was included in all nurse and QMA training at the start of the facility utilizing the EZ Mar system. (This information was given to the surveyor who attended this complaint survey/see attached). As per the 9/24/25/2012 survey statement(s): "Further interview...the staff member who identified herself as one of the training staff who came to the facility (for the EZ Mar training).....indicated this function (the LOCK button) was discussed at the training sessions and was contained within the (pharmacy EZ Mar) handbook." On 9-06-2012, controlled medication</p>		

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	<p>However the electronic medication administration record for the time period of September 10, 2012 through September 17, 2012 indicated the resident received the medication on 3 occasions - 09-12-12 at 17:18 [5:18 p.m.], 09-13-12 08:46 [8:46 a.m.] and 09-16-12 at 20:19 [8:19 p.m.].</p> <p>3. The record for Resident "A" was reviewed on 09-24-12 at 2:30 p.m. Diagnoses included but were not limited to cancer with metastasis, cellulitis, personality disorder and depression. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders dated 02-12-12 for Oxycodone-Acetaminophen 10-325 two tablets by mouth three times a day as needed for back and leg pain, two tablets by mouth for complaint of severe pain every 6 hours as needed, and one tablet every 6 hours for complaints of moderate pain.</p>		<p>sheets were found to be absent, by the Director of Nursing. The facility immediately contacted all parties required by regulations, including an ISDH report and IMPD. (IE: "turned itself in"), this complaint survey occurred on 9/24 and 9/25, 2012. Pharmacy EZ Mar Staff Training has been scheduled at this time, to ensure that all staff associated with medications administration, are trained properly on the use of this system. The facility has also requested an enhancement be done to the EZ Mar electronic Medication system, where the actual # of medication (narcotics) remaining on the medication cart, be accounted for electronically. In addition: The Director of Nursing and the Executive Director of the facility will also be attending a seminar offered by NADDIE on October 24th and 25th 2012 on drug diversion in long term care facilities. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? The facility maintains that it does indeed take many varied steps to ensure that misappropriation of resident's property does not occur. In our humble opinion, the facility nursing staff did not fail to perform random reconciliation of the medications. Corrective actions: (IE: additional measures put into place by the facility): A sheet has been added to the</p>				

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	<p>The resident's current plan of care originally dated 09-04-09 indicated the resident was at risk for pain related to diabetic neuropathy and history of compression fractures in back, lung cancer, and arthritis."</p> <p>Interview on 09-24-12 at 2:50 p.m. Qualified Medication Aide employee #8 indicated the resident requested the pain medication every morning usually "around 6:00 a.m."</p> <p>Review of the electronic medication administration record for August 2012 indicated the resident received the medication on August 2nd 04:50 [4:50 a.m.], 07:28 [7:28 a.m.], 21:45 [9:45 p.m.], August 3rd 07:46 [7:46 a.m.], August 5th at 05:08 [5:08 a.m.] and 07:08 [7:08 a.m.], August 6th 04:57 [4:57 a.m.], August 7th at 05:05 [5:05 a.m.], August 8th 15:17 [3:17 p.m.], August 9th 04:47 [4:47 a.m.], August 10th 16:02 [4:02 p.m.], August 11th 01:35 [1:35 a.m.], August 12th 05:50 [5:50</p>		<p>medication count to show the number of bubble packs (medication containers/narcotic card count sheet) that are present on the cart. This sheet also accounts for all bubble packs that are newly delivered or removed from the cart. (see attached) Un-announced narcotic reconciliation counts are done on a weekly basis by the Director of Nursing, the Executive Director or the Assistant Director of Nursing. During these reconciliation counts, the narcotics, the narcotic sign in and sign off sheets are also monitored. The Director of Nursing or her designee is also closely monitoring the Daily Activity Medication Log (see attached) as it is provided to her by the pharmacy. Un-scheduled narcotic counts are also being done on a weekly basis by the DON, ADON or LHFA (LPN). Once per week the DON or ADON will approach the night/day shift nurse to reconcile the daily delivered medication manifests. The facility now drug tests any new hire nurses and QMA. Quality assurance : Documentation for all aforementioned paperwork and paperwork checks, are monitored by the Director of Nursing or the ADON. The aforementioned changes are assigned no stop date and will continue at the least for the next 6 (six) months; at that time the efficiency of these paperwork changes will be</p>		

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NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
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	<p>a.m.], August 13th 05:07 [5:07 a.m.] and 08:08 [8:08 a.m.], August 14th 04:56 [4:56 a.m.], and 07:38 [7:38 a.m.], August 16th 05:09 [5:09 a.m.], August 20th 21:22 [9:22 p.m.], August 22 06:07 [6:07 a.m.], August 25th 15:28 [3:28 p.m.], August 27th 21:41 [9:41 p.m.], and August 31st 17:14 [5:14 p.m.] - 23 occasions.</p> <p>A request was made to review the "Controlled Drug Record - Individual Patient's Narcotic Record," for the month of August 2012. The facility was unable to provide the documentation for review.</p> <p>4. The record for Resident "D" was reviewed on 09-25-12 at 9:30 a.m. Diagnoses included but were not limited to dementia with agitation, depression, mild mental retardation, neuropathy, paranoia and delusions. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order</p>		<p>re-evaluated. All paperwork/monitoring forms etc, will be discussed in a monthly Quality Assurance meeting. The Director of Nursing will maintain a log on this paperwork and the discussions during the facility's QA meetings. New employees who are licensed or certified by the State of Indiana to administer medications will be drug tested upon hire or within 30 (thirty) days of hire. The facility drug testing policy will be adhered to and this will have no stop date. The LHFA will maintain and monitor the drug test results . Positive employee drug tests will be immediately reported to the ISDH,</p> <p>5) By what date will the corrections be completed? October 25th, 2012</p>	

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	<p>dated 05-03-12 for Hydrocodone-Acetaminophen 5-500 2 tablets every 4 hours as needed for moderate pain or severe pain as needed.</p> <p>The resident's current plan of care, originally dated 02-26-12 indicated the resident "is at risk for pain related to complaints of bilateral knee pain and diagnosis of neuropathy."</p> <p>Review of the electronic medication administration record for August 2012 indicated the resident received the medication on August 1st 17:29 [5:29 p.m.], August 6th 04:39 [4:39 a.m.] and again at 19:28 [7:28 p.m.], August 9th 04:25 [4:25 a.m.], August 11th 08:17 [8:17 a.m.], August 13th 08:16 [8:16 a.m.], August 26th 21:21 [11:21 p.m.], August 27th 00:41 [12:41 a.m.], and August 31st 14:29 [2:29 p.m.] - 9 occasions.</p> <p>Review of the "Controlled Drug</p>				

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	<p>Record - Individual Patient's Narcotic Record," for August 2012 indicated the resident received the medication as follows: August 4th at 2:30 p.m., August 5th at 3:00 a.m., August 6th at 5:30 a.m., and 8:30 p.m., August 7th 5:00 a.m., and 5:00 p.m. [three tablets], August 9th 5:00 a.m., 10:00 a.m., and 2:00 a.m. and 6:00 p.m., August 12th 5 a.m., 3:30 p.m., and 8:00 p.m., August 13th at 8:00 a.m., August 14th 9:30 a.m., and 1:30 p.m., August 16th at 7:00 a.m., 11:00 a.m. and 3:00 p.m., August 18 th 2:00 a.m., 8:00 a.m., and 1:00 p.m., August 19th 1:00 a.m., August 20th 10:00 a.m., 2:00 p.m., August 24 4:00 a.m., 9:00 a.m., and 3:00 p.m., August 28th 4:00 a.m., August 29th 9:00 a.m., August 31, 6:00 a.m. and 10:00 a.m. - 32 occasions.</p> <p>Review of the electronic medication administration record for September 2012 indicated the resident did not receive any of the prescribed medication, however</p>			

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	<p>review of the "Controlled Drug Record - Individual Patient's Narcotic Record," for September 2012 indicated the resident received the medication on 09-01-12 at 4:00 a.m., 8:00 a.m., 12:00 p.m., and 09-03-12 at 5:00 a.m. - 4 occasions.</p> <p>5. Observation on 09-24-12 at 1:30 p.m., Licensed Practical Nurse employee #10 was standing at the medication carts. A request was made to reconcile the controlled medications prn [as needed] medications for the residents. The nurse requested the keys for the medication carts from Qualified Medication Aide employee #8. The nurse unlocked the cart and then unlocked the secured controlled box which was contained within the medication cart.</p> <p>There were 3 supplemental sampled residents [Resident's "E", "F" and "G"] medications reviewed in addition to the sampled residents. The reconciliation of all</p>						

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	<p>medications were accurate with the exception of Resident "E" who's actual medication package observed were 57 tablets of Hydrocodone 3-325 mg and the "Controlled Drug Record - Individual Patient's Narcotic Record," for September 2012 indicated the "count" was 58.</p> <p>Interview on 09-24-12 at 1:40 p.m., Licensed Practical Nurse employee #10 indicated the QMA [Qualified Medication Aide] employee #8 "probably forgot to sign the med. [medication] out."</p> <p>Interview on 09-24-12 at 2:00 p.m., Qualified Medication Aide employee #8 returned to the medication cart and indicated she "forgot to sign out" the medication for Resident "E."</p> <p>Interview on 09-24-12 at 2:50 p.m., the QMA indicated she had "not yet" signed out the medication for the resident.</p> <p>6. Observation on 09-24-12 at 2:15 p.m., all three computers attached</p>						

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	<p>to the medication and treatment carts had the lids open. When interviewed if anyone could chart under another persons password, Licensed Practical Nurse employee #10 indicated she didn't know. The Licensed Nurse placed her fingertip onto the mouse pad and the computer "opened" to a medication record and the computer screen indicated the "user" was QMA employee #8. The additional two computer mouse pads were touched and the computer screen appeared with a resident medication record and the "current user."</p> <p>During interview the Licensed Practical Nurse indicated she was unaware of how to secure the computer so entry be an unauthorized person could be attempted. "I usually sign out the entire way and then when I have to get into the computer I sign back in."</p> <p>Interview on 09-25-12 at 8:45 a.m., a representative from the local area</p>						

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	<p>Pharmacy indicated when a staff member leaves the vicinity of the computer, the staff member needs to press the "lock" key, and then upon return, touch the mouse pad and the user will be prompted to enter their password. Further interview the staff member who identified herself as one of the training staff who came to the facility to train the nurses and Administrative staff last October [2011] indicated this function was discussed at the training sessions and was contained within the handbook.</p> <p>Interview on 09-25-12 at 9:30 a.m., the Director of Nurses indicated she was unaware of the "lock" function. Additional interview on 09-25-12 at 9:15 a.m., Licensed Practical Nurse employee #10 indicated she was not aware of the "lock" function to protect the electronic medication administration record. Interview on 09-25-12 at 2:40 p.m., the Assistant Director of Nurses indicated she was not trained on the</p>				

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	<p>"lock" function of the electronic medication administration record. Interview on 09-25-12 at 3:00 p.m., the Administrator indicated the Easy Mar [electronic medication administration record] handbook did not contain information in regard to the "lock" function.</p> <p>Review of an "Unsatisfactory Work Report," dated 08-29-12 in regard to Registered Nurse employee #3 indicated the following: "PRN narcotics are given to resident and signed out for controlled drug record, however several are not documented on the MAR [medication administration record] and/or the nurses notes. Facility policy states that PRN medications <sic> are to be assessed by the nurse, rated on a scale to 1-10 (10 being the worst) and re-evaluated for effectiveness and rated from 1-10. Not only is this a violation of policy, it also presents an unclear picture of frequency of pain. Also discussed signing out meds given by someone else and signing out</p>			

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	<p>meds under another employees computer ID [identification]. This employee report was signed by Registered Nurse employee #3.</p> <p>Review of the facility Hipaa Policy, undated, on 09-25-12 at 1:45 p.m., indicated the following: "Purpose [bold type and underscored] - To ensure the facility's uses and disclosures of Protected Information (PHI) are limited to the minimum necessary to accomplish the intended purpose."</p> <p>"Types of Violation [bold type]" included "improper protection of medical records or other PHI, failure to properly safeguard or store PHI, careless handling of user names and passwords, and inadequate information security training procedures."</p> <p>"Examples of purposeful violations include: allowing another employee to utilize any systems via your password."</p>				

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	<p>7. Review of the "Narcotic Sign Off Sheets," for the two medication carts contained numerous omissions in regard to the required signatures between shifts and accountability for the nursing staff. In addition the same staff member would sign themselves as the "signing in" staff member as well as the "signed out" staff member.</p> <p>Interview on 09-24-12 at the Exit conference at 3:15 p.m., the Director of Nurses reviewed the narcotic Count Sign Off Sheets and indicated she was unaware the nurses were not completing the document correctly or that the same staff member was signing themselves "in" and "out."</p> <p>The "Controlled Drug Record - Individual Patient's Narcotic Records" for Residents "H", "I", "J", "K", "L", and "M" were reviewed. The record had numerous notations in which the "doses present" had been lined through and the declining dosage</p>						

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	<p>changed by handwriting over the typed number and changed to reflect the current count.</p> <p>Interview on 09-24-12 at 3:15 p.m., during the Exit Conference, the Director of Nurses indicated she was unaware of the changes made to the "Controlled Drug Record - Individual Patient's Narcotic Records."</p> <p>The directions at the top of the "Narcotic Count Sign Off Sheet," indicated and instructed the nurses as follows:</p> <p>"I the undersigned hereby accept complete responsibility for my signature and the condition of the narcotics that are under double lock on this medication care and inside the locked medication refrigerator. I am aware that a licensed nurse is required by law and facility policy to count the medications (narcotics) at the beginning and at the end of each shift, with another licensed</p>			

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	<p>nurse or a Qualified Medication Aide. I am also aware that this facility has two medication carts (i.e. narcotic counts) and that the refrigerator in the locked medication room must also be counted. As the licensed nurse I am aware that I am responsible for all narcotics for my shift, inside the facility, that a deviance in the narcotic count required immediate notification of the Director of nursing, that the D.O.N. [Director of Nurses] may instruct the licensed nurses to call the police due to the narcotic deviance."</p> <p>Interview on 09-24-12 at 3:15 p.m., during the Exit Conference, the Director of Nurses indicated she was unaware of the omissions to the "Narcotic Count Sign Off Sheet." "The nursing staff never turned these sheets in to me."</p> <p>Review of a "Lynhurst Healthcare" undated policy on 09-25-12 at 2:20 p.m. indicated the following:</p>			

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	"Narcotic Count Sign Off Sheet [bold type and underscored] - The nurse or the QMA should understand and hereby accept complete responsibility for signatures and the condition of the narcotics that are under double lock on this medication cart and inside the locked medication room refrigerator. Be aware that a licensed nurse is required by law and facility policy to count the medications (narcotics) at the beginning and at the end of each shift, with another licensed nurse or a Qualified mediations Aide. Both nurses are to sign the narcotic count sheet. I am also aware that this facility has two medication carts (i.e. narcotic counts) and that the refrigerator in the locked medication room must also be counted. As the licensed nurse I am aware that I am responsible for all narcotics for my shift, inside the facility that a deviance in the narcotic count required immediate notification of the Director of Nursing; that the police are to be			

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	<p>called due to the narcotic discrepancy."</p> <p>8. Interview on 09-24-12 at 1:15 p.m., the licensed nurse representative from the local area Pharmacy indicated she had been called by the facility staff due to the concern of drug diversion. The representative also indicated additional problems with the controlled count sheets, pharmacy manifests and no reconciliation of the drugs and sheets."</p> <p>9. Review of the "Cart Audits Forms," from the local area pharmacy indicated Cart Audits were conducted on January 3, 2012, January 4, 2012, February 6, 2012, March 12, 2012, and July 12, 2012 lacked documentation a reconciliation was conducted, to identify omissions in the narcotic shift count sheet, alteration of the narcotics, possible drug diversion, documentation of error on the controlled drug sheet or PRN medications not documented</p>						

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	<p>correctly.</p> <p>Review of the facility policy titled "Lynhurst healthcare - Abuse Prevention," originally dated 12-02-16 and revised 09-17-12 indicated, "Every resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, or volunteers, staff of other agencies servicing the resident, family members or legal guardians, friends or other individuals."</p> <p>"All allegations of abuse are to be reported immediately to the Administrator or her designee: the Director of Nursing."</p> <p>"Types of abuse - Misappropriation of resident property is the deliberate misplacement, exploitation or wrongful (whether temporary or permanent) use of a</p>						

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	<p>resident belongings or money without the resident's consent."</p> <p>This Federal tag relates to Complaint IN00115340.</p> <p>3.1-28(a) 3.1-28(c)</p>			

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F0226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, record review and interview the facility failed to ensure the implementation of their policy to ensure there was no misappropriation of resident property for 3 of 4 sampled and 9 of 9 supplemental sampled residents. [Residents "A", "C" and "D"] and 9 of 9 supplemental sampled residents reviewed. [Residents "E", "F", "G" "H", "I", "J", "K", "L" and "M"].</p> <p>Findings include:</p> <p>1. Interview on 09-24-12 at 8:40 a.m., the Director of Nurses indicated staff from the Attorney Generals office had been "in and out of the facility for the past few weeks investigating drug diversion," which involved at least 3 residents and possibly 4 staff members [employees Registered</p>	F0226	<p>1) F0226 What action(s) will be accomplished for those residents found to have been affected? Any resident has the potential to be affected by this deficiency. No resident of this facility been noted or reported to have any ill effect regarding this complaint. On 9-06-2012, controlled medication sheets were found to be absent, by the Director of Nursing. The facility immediately contacted all parties required by regulations, including an ISDH report and IMPD. (IE: "turned itself in"), this complaint survey occurred on 9/24 and 9/25, 2012. The facility maintains that it does indeed take many varied steps to ensure that misappropriation of resident's property does not occur. (see policies , exhibit A, #'s 1 and 2) By virtue of a Registered Nursing licensure, a Licensed Practical Nurse licensure and/or a certificate for a Qualified Medication Aide (issued by the State of Indiana) and by facility policy, these employees may administer and sign off for narcotic medications. The facility's job description for staff nurses defines the licensed staff duties in</p>	10/25/2012	

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	<p>Nurses employees #3 and #4 and Qualified Medications Aides employees #8 and #9]. "What was happening was the nurses were not turning in the controlled sheets to me, so I wasn't aware of what was going on. After I spoke with [name of Qualified Medication Aide employee #8] I started to look at it."</p> <p>Continued interview on 09-24-12 at 9:00 a.m., the Administrator indicated all nursing staff who worked during a specific time frame had been determined, and were sent for "drug tests."</p> <p>The Administrator indicated Registered Nurse employee #3 tested positive, while Registered Nurse employee #4 refused the testing. Registered Nurse employee #4 was terminated on 09-09-12 and Registered Nurse employee #3 was terminated on 09-10-12. Testing on Qualified Medication Aide employee #9 also tested positive and was terminated on 09-24-12, while Qualified</p>		<p>detail. (see exhibit 'F'- for licensed staff and exhibit 'G'--for certified staff) The facility requires two licensed staff or a licensed nurse and a Qualified Medication Aide, to sign off on all medications and to take additional precautionary measures with the narcotic count (s). (see attached policies-exhibits A #2 and exhibit B) The facility's policies and procedures have always been in place and are updated frequently. (Please see exhibit 'H', as an example) Our staff is also in-serviced on facility policy and procedures as per regulations of the state and extensively beyond those regulations. The facility includes 8 video surveillance cameras (now 10 cameras, as of 10/2/2012) in it's ongoing efforts to secure the building and to ensure that misappropriation does not occur. All medication and treatment carts are also stored under surveillance cameras. On 9-06-2012, controlled medication sheets were found to be absent, by the Director of Nursing. The facility immediately contacted all parties required by regulations, including an ISDH report and IMPD. (IE: "turned itself in"), this complaint survey occurred on 9/24 and 9/25, 2012. Once the facility was made aware of the possibility/allegations of an issue with medications, the facility</p>				

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	<p>Medication Aide employee #8 tested negative for drugs.</p> <p>Interview on 09-24-12 at 2:50 p.m., Qualified Medication Aide employee #6 indicated she showed the Director of Nurses a copy of the electronic medication administration record for Resident "C" which indicated by her initials that she dispensed Oxycodone 5/325 mg [milligrams] [a controlled pain medication] to Resident "C", while the Controlled drug sheet clearly showed the medications had been "signed out" by Registered Nurse employee #3. "[Name of Registered Nurse employee #3] came and got the keys to the controlled drugs a lot, if [Registered Nurse employee #3] felt the residents needed the prn [as needed medications], [Registered Nurse employee #3] passed them, under my initials. [Name of Resident "C"] would hardly take routine medications, it was a struggle, let alone the Oxycodone." When further interviewed the</p>		<p>immediately contacted all parties required by regulations, including an ISDH report. Drug test were completed on those staff, in the time frame that was indicated, who had contact with the medication carts. The facility policy is that any staff may be drug tested at random any time and should a positive drug test result, or should an employee refuse a drug test, the employee will be terminated. As a result of those drug tests, three staff members were terminated immediately. The alleged drug diversion remains under the scrutiny of the Attorney General's Office Drug Diversion Unit and the IMPD. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Any resident has the potential to be affected by this deficiency. The facility maintains that it does indeed take many varied steps to ensure that misappropriation of resident's property does not occur. The protection of our resident's is our facility's main concern, in all aspects of their care. The facility's policies and procedures have always been in place and are updated frequently. (These policies include misappropriation of resident belongings, drug reconciliation and many more.) Our staff is also in-serviced on facility policy and procedures as per regulations of the state and</p>				

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	<p>Qualified Medication Aide employee #6 indicated with the electronic medication record system, if she had to leave the cart unattended, she would close the lid of the computer. "Now I know we're suppose to log out so no one can document under my password." When interviewed if there were any complaints from the resident's about the pain medications, the Qualified Medication aide indicated "No, because most of the resident's don't know or understand the types of medications that are ordered due to their diagnoses."</p> <p>2. The record for Resident "C" was reviewed on 09-24-12 at 1:00 p.m. Diagnoses included but were not limited to affective psychosis, bipolar disorder, alcohol abuse, cerebral palsy and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order, dated 07-11-12 for Oxycodone-Apap 5/325 mg</p>		<p>extensively beyond those regulations. The facility includes 8 video surveillance cameras (now 10 cameras, as of 10/2/2012) in it's ongoing efforts to secure the building and to ensure that misappropriation does not occur. All medication and treatment carts are also stored under surveillance cameras. In our humble opinion, the facility nursing staff did not fail to perform random reconciliation of the medications. The facility is contracted with a pharmacy who provides scheduled audits of all medication carts. These audits take place on a scheduled basis. The results of these audits are then given to the Director of Nursing who follows up on any possible issues. The State of Indiana determined it is appropriate to issue nursing licensures and (Certified) Qualified Medication Aide certificates to those who qualify: and the facility relies on those employees who have been issued such documents by the state, to have the full training and the understanding of their scope of practices regarding medication pass/administration rules and regulations, prior to being hired by this facility. However, the facility's policies and procedures are in place and are updated frequently and our staff is also in-serviced on facility policy and procedures as per regulations of the state and extensively beyond</p>				

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	<p>[milligrams] by mouth every 6 hours as needed for pain.</p> <p>The resident's current plan of care, originally dated 02-06-12 indicated the resident had "actual complaints of pain to left lower leg," and a subsequent plan of care dated 02-09-12 for "headaches on occasion."</p> <p>Review of the electronic medication administration record indicated the resident received the medication on the following dates: August [2012] 1st at 17:12 [5:12 p.m.], August 2nd at 21:46 [9:46 p.m.], August 8th at 15:16 [3:16 p.m.] and 21:39 [9:39 p.m.], August 9th 05:01 [5:01 a.m.], August 11th 08:31 [8:31 a.m.] and 20:53 [8:53 p.m.], August 18 th 19:34 [7:34 p.m.], August 20th 22:03 [10:03 p.m.], August 23rd 18:17 [6:17 p.m.], August 27th 10:08 [10:08 a.m.] and 22:01 [10:01 p.m.], and August 31st 09:21 [09:21 a.m.] 11:12 [11:12 a.m.] and 17:27 [5:27 p.m.] - 15 occasions.</p>		<p>those regulations. Each licensed nurse and QMA (Qualified Medication Aide) also goes through an orientation process, once hired by the facility, to ensure that rules and regulations of the medication pass (but not limited to the medication pass) are explained and followed. Licenses and certifications are checked for validity and any litigation that is available on the "search and verify" state internet site. The facility also maintains an employee drug policy. By virtue of a Registered Nursing licensure, a Licensed Practical Nurse licensure and/or a certificate for a Qualified Medication Aide and by facility policy, these employees may administer and sign off for narcotic medications. The facility requires two licensed staff or a licensed nurse and a Qualified Medication Aide, to sign off on all medications and to take additional precautionary measures with the narcotic count (s). (see attached policys')</p> <p>QMA #6 has been given written council for not signing off on the EZ Mar Medication Pass system when not in direct use and allowing another employee to pass medications under her electronic signature.(see attached) QMA#6 has been re-educated on the basics of the EZ Mar Medication Pass system, including the "LOCK" button on the computer that allows the staff</p>				

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	<p>Review of the handwritten "Controlled Drug Record - Individual Patient's Narcotic Record" indicated the resident received the medication as follows: August 5th at 3:00 a.m., 9:00 a.m. and 3:00 p.m., August 6th at 2:00 a.m., 10:30 a.m., 4:30 p.m., 10:30 p.m., August 7th at 4:30 a.m., 3:30 p.m., and 9:30 p.m., August 8th at 3:00 p.m., and 9:30 p.m., August 9th at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 8:00 p.m., August 10th at 3:00 a.m., August 11th at 8:00 a.m., 2:00 p.m., and 8:00 p.m., August 12 at 3:00 a.m., 10:00 a.m., and 4:00 p.m., August 13th 12:00 a.m., 6:00 a.m., 2:00 p.m., August 14th at 2:00 p.m., August 15th at 6:30 a.m., August 16th at 8:00 a.m., and 2:00 p.m. - 30 occasions.</p> <p>The facility was unable to provide the "Controlled Drug Record - Individual Patient's Narcotic Record," for the remainder of August 2012. Interview with the Director of Nurses on 09-24-12 at</p>		<p>to close out their computer when not in use. This "LOCK" button was included in all nurse and QMA training at the start of the facility utilizing the EZ Mar system. (This information was given to the surveyor who attended this complaint survey/see attached). As per the 9/24/25/2012 survey statement(s): "Further interview...the staff member who identified herself as one of the training staff who came to the facility (for the EZ Mar training)....indicated this function (the LOCK button) was discussed at the training sessions and was contained within the (pharmacy EZ Mar) handbook." The facility also provided the survey team member with the facility policy regarding HIPPA and electronic information (computers, faxes and the EZ Mar system) (Please see exhibit E) 3) What measures will be put into place or what systemic changes will be made ? At this time the facility has put additional measures into place for narcotic counts. (Beginning 9-14-2012) However, the facility's policies and procedures are in place and are updated frequently. Our staff is also in-serviced on facility policy and procedures as per regulations of the state and beyond. A sheet has been added to show the number of bubble packs (medication containers/narcotic card count</p>		

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	<p>9:00 a.m., indicated "that was part of the problem, the Controlled Drug Records are missing."</p> <p>Review of the electronic medication administration record for September 1, 2012 thru September 10, 2012 indicated the resident received the medication on 9 occasions, however the "Controlled Drug Record - Individual Patient's Narcotic Record" for the same time period could not be located by facility staff, and a new "Controlled Drug Record - Individual Patient's Narcotic Record," was started for the resident on 09-10-12 which indicated the resident received the medication on 09-12-12 at 5:30 p.m., 09-13-12 at 8:30 p.m., 09-16-12 at 9:00 p.m., and 09-17-12 at 7:00 p.m.</p> <p>However the electronic medication administration record for the time period of September 10, 2012 through September 17, 2012 indicated the resident received the</p>		<p>sheet) that are present on the cart. This sheet also accounts for all bubble packs that are newly delivered or removed from the cart. (see attached exhibit C)</p> <p>Un-announced narcotic reconciliation counts are done on a weekly basis by the Director of Nursing, the Executive Director or the Assistant Director of Nursing. During these reconciliation counts, the narcotics, the narcotic sign in and sign off sheets are also monitored. The Director of Nursing or her designee is also closely monitoring the Daily Activity Medication Log (see attached) as it is provided to her by the pharmacy. Un-scheduled narcotic counts are also being done on a weekly basis by the DON, ADON or LHFA (LPN). Once per week the DON or ADON will approach the night/day shift nurse to reconcile the daily delivered medication manifests. (please see exhibit D)</p> <p>Pharmacy has been contacted and continues to work with the facility to improve our medications passes and to ensure misappropriation/allegations of, do not occur. Pharmacy is scheduled at this time to complete cart audits of both medication carts, on a monthly basis; including narcotic reconciliation. Pharmacy has also agreed to send a nurse auditor to our facility once a month for the next three months to audit al narcotics, including</p>		

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	<p>medication on 3 occasions - 09-12-12 at 17:18 [5:18 p.m.], 09-13-12 08:46 [8:46 a.m.] and 09-16-12 at 20:19 [8:19 p.m.].</p> <p>3. The record for Resident "A" was reviewed on 09-24-12 at 2:30 p.m. Diagnoses included but were not limited to cancer with metastasis, cellulitis, personality disorder and depression. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders dated 02-12-12 for Oxycodone-Acetaminophen 10-325 two tablets by mouth three times a day as needed for back and leg pain, two tablets by mouth for complaint of severe pain every 6 hours as needed, and one tablet every 6 hours for complaints of moderate pain.</p> <p>The resident's current plan of care originally dated 09-04-09 indicated the resident was at risk for pain related to diabetic neuropathy and</p>		<p>narcotic sign out sheets, manifests and the medications themselves. Continuation of monthly audits after the three month period will be accomplished by a pharmacy technician and the aforementioned changes regarding auditing, by the facility management staff. The facility has also requested an enhancement be done to the EZ Mar electronic Medication system, where the actual # of medication remaining on the medication cart, be accounted for electronically. The Director of Nursing and the Executive Director of the facility will also be attending a seminar offered by NADDIE on October 24th and 25th 2012 on drug diversion in long term care facilities. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor?</p> <p>The facility maintains that it does indeed take many varied steps to ensure that misappropriation of resident's property does not occur. In our humble opinion, the facility nursing staff did not fail to perform random reconciliation of the medications. Corrective actions: (IE: additional measures put into place by the facility): A sheet has been added to the medication count to show the number of bubble packs (medication containers/narcotic card count sheet) that are present</p>				

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	<p>history of compression fractures in back, lung cancer, and arthritis."</p> <p>Interview on 09-24-12 at 2:50 p.m. Qualified Medication Aide employee #8 indicated the resident requested the pain medication every morning usually "around 6:00 a.m."</p> <p>Review of the electronic medication administration record for August 2012 indicated the resident received the medication on August 2nd 04:50 [4:50 a.m.], 07:28 [7:28 a.m.], 21:45 [9:45 p.m.], August 3rd 07:46 [7:46 a.m.], August 5th at 05:08 [5:08 a.m.] and 07:08 [7:08 a.m.], August 6th 04:57 [4:57 a.m.], August 7th at 05:05 [5:05 a.m.], August 8th 15:17 [3:17 p.m.], August 9th 04:47 [4:47 a.m.], August 10th 16:02 [4:02 p.m.], August 11th 01:35 [1:35 a.m.], August 12th 05:50 [5:50 a.m.], August 13th 05:07 [5:07 a.m.] and 08:08 [8:08 a.m.], August 14th 04:56 [4:56 a.m.], and 07:38 [7:38 a.m.], August 16th 05:09 [5:09 a.m.], August 20th 21:22</p>		<p>on the cart. This sheet also accounts for all bubble packs that are newly delivered or removed from the cart. (see attached) Un-announced narcotic reconciliation counts are done on a weekly basis by the Director of Nursing, the Executive Director or the Assistant Director of Nursing. During these reconciliation counts, the narcotics, the narcotic sign in and sign off sheets are also monitored. The Director of Nursing or her designee is also closely monitoring the Daily Activity Medication Log (see attached) as it is provided to her by the pharmacy. Un-scheduled narcotic counts are also being done on a weekly basis by the DON, ADON or LHFA (LPN). Once per week the DON or ADON will approach the night/day shift nurse to reconcile the daily delivered medication manifests. (Please see exhibits 'C' and 'D')</p> <p>Quality assurance : Documentation for all aforementioned paperwork and paperwork checks, are monitored by the Director of Nursing or the ADON. The aforementioned changes are assigned no stop date and will continue at the least for the next 6 (six) months; at that time the efficiency of these paperwork changes will be re-evaluated. All paperwork/monitoring forms etc, will be discussed in a monthly Quality Assurance meeting. The Director of Nursing will maintain a</p>				

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	<p>[9:22 p.m.], August 22 06:07 [6:07 a.m.], August 25th 15:28 [3:28 p.m.], August 27th 21:41 [9:41 p.m.], and August 31st 17:14 [5:14 p.m.] - 23 occasions.</p> <p>A request was made to review the "Controlled Drug Record - Individual Patient's Narcotic Record," for the month of August 2012. The facility was unable to provide the documentation for review.</p> <p>4. The record for Resident "D" was reviewed on 09-25-12 at 9:30 a.m. Diagnoses included but were not limited to dementia with agitation, depression, mild mental retardation, neuropathy, paranoia and delusions. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order dated 05-03-12 for Hydrocodone-Acetaminophen 5-500 2 tablets every 4 hours as needed for moderate pain or severe pain as needed.</p>		<p>log on this paperwork and the discussions during the facility's QA meetings. Quality assurance : New employees who are licensed or certified by the State of Indiana to administer medications will be drug tested upon hire or within 30 (thirty) days of hire. The facility drug testing policy will be adhered to and this will have no stop date. The LHFA will maintain and monitor the drug test results . Positive employee drug tests will be immediately reported to the ISDH,</p> <p>5) By what date will the corrections be completed? October 25th, 2012</p>	

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	<p>The resident's current plan of care, originally dated 02-26-12 indicated the resident "is at risk for pain related to complaints of bilateral knee pain and diagnosis of neuropathy."</p> <p>Review of the electronic medication administration record for August 2012 indicated the resident received the medication on August 1st 17:29 [5:29 p.m.], August 6th 04:39 [4:39 a.m.] and again at 19:28 [7:28 p.m.], August 9th 04:25 [4:25 a.m.], August 11th 08:17 [8:17 a.m.], August 13th 08:16 [8:16 a.m.], August 26th 21:21 [11:21 p.m.], August 27th 00:41 [12:41 a.m.], and August 31st 14:29 [2:29 p.m.] - 9 occasions.</p> <p>Review of the "Controlled Drug Record - Individual Patient's Narcotic Record," for August 2012 indicated the resident received the medication as follows: August 4th at 2:30 p.m., August 5th at 3:00</p>			

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NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
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	<p>a.m., August 6th at 5:30 a.m., and 8:30 p.m., August 7th 5:00 a.m., and 5:00 p.m. [three tablets], August 9th 5:00 a.m., 10:00 a.m., and 2:00 a.m. and 6:00 p.m., August 12th 5 a.m., 3:30 p.m., and 8:00 p.m., August 13th at 8:00 a.m., August 14th 9:30 a.m., and 1:30 p.m., August 16th at 7:00 a.m., 11:00 a.m. and 3:00 p.m., August 18 th 2:00 a.m., 8:00 a.m., and 1:00 p.m., August 19th 1:00 a.m., August 20th 10:00 a.m., 2:00 p.m., August 24 4:00 a.m., 9:00 a.m., and 3:00 p.m., August 28th 4:00 a.m., August 29th 9:00 a.m., August 31, 6:00 a.m. and 10:00 a.m. - 32 occasions.</p> <p>Review of the electronic medication administration record for September 2012 indicated the resident did not receive any of the prescribed medication, however review of the "Controlled Drug Record - Individual Patient's Narcotic Record," for September 2012 indicated the resident received the medication on</p>			

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	<p>09-01-12 at 4:00 a.m., 8:00 a.m., 12:00 p.m., and 09-03-12 at 5:00 a.m. - 4 occasions.</p> <p>5. Observation on 09-24-12 at 1:30 p.m., Licensed Practical Nurse employee #10 was standing at the medication carts. A request was made to reconcile the controlled medications prn [as needed] medications for the residents. The nurse requested the keys for the medication carts from Qualified Medication Aide employee #8. The nurse unlocked the cart and then unlocked the secured controlled box which was contained within the medication cart.</p> <p>There were 3 supplemental sampled residents [Resident's "E", "F" and "G"] medications reviewed in addition to the sampled residents. The reconciliation of all medications was accurate with the exception of Resident "E" who's actual medication package observed were 57 tablets of Hydrocodone 3-325 mg and the</p>						

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	<p>"Controlled Drug Record - Individual Patient's Narcotic Record," for September 2012 indicated the "count" was 58. Interview on 09-24-12 at 1:40 p.m., Licensed Practical Nurse employee #10 indicated the QMA [Qualified Medication Aide] employee #8 "probably forgot to sign the med. [medication] out."</p> <p>Interview on 09-24-12 at 2:00 p.m., Qualified Medication Aide employee #8 returned to the medication cart and indicated she "forgot to sign out" the medication for Resident "E." Interview on 09-24-12 at 2:50 p.m., the QMA indicated she had "not yet" signed out the medication for the resident.</p> <p>6. Observation on 09-24-12 at 2:15 p.m., all three computers attached to the medication and treatment carts had the lids open. When interviewed if anyone could chart under another persons password, Licensed Practical Nurse employee</p>						

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	<p>#10 indicated she didn't know. The Licensed Nurse placed her fingertip onto the mouse pad and the computer "opened" to a medication record and the computer screen indicated the "user" was QMA employee #8. The additional two computer mouse pads were touched and the computer screen appeared with a resident medication record and the "current user."</p> <p>During interview the Licensed Practical Nurse indicated she was unaware of how to secure the computer so entry be an unauthorized person could be attempted. "I usually sign out the entire way and then when I have to get into the computer I sign back in."</p> <p>Interview on 09-25-12 at 8:45 a.m., a representative from the local area Pharmacy indicated when a staff member leaves the vicinity of the computer, the staff member needs to press the "lock" key, and then upon return, touch the mouse pad</p>				

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	<p>and the user will be prompted to enter their password. Further interview the staff member who identified herself as one of the training staff who came to the facility to train the nurses and Administrative staff last October [2011] indicated this function was discussed at the training sessions and was contained within the handbook.</p> <p>Interview on 09-25-12 at 9:30 a.m., the Director of Nurses indicated she was unaware of the "lock" function. Additional interview on 09-25-12 at 9:15 a.m., Licensed Practical Nurse employee #10 indicated she was not aware of the "lock" function to protect the electronic medication administration record. Interview on 09-25-12 at 2:40 p.m., the Assistant Director of Nurses indicated she was not trained on the "lock" function of the electronic medication administration record. Interview on 09-25-12 at 3:00 p.m., the Administrator indicated the Easy Mar [electronic medication</p>						

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	<p>administration record] handbook did not contain information in regard to the "lock" function.</p> <p>Review of an "Unsatisfactory Work Report," dated 08-29-12 in regard to Registered Nurse employee #3 indicated the following: "PRN narcotics are given to resident and signed out for controlled drug record, however several are not documented on the MAR [medication administration record] and/or the nurses notes. Facility policy states that PRN medications <sic> are to be assessed by the nurse, rated on a scale to 1-10 (10 being the worst) and re-evaluated for effectiveness and rated from 1-10. Not only is this a violation of policy, it also presents an unclear picture of frequency of pain. Also discussed signing out meds given by someone else and signing out meds under another employees computer ID [identification]. This employee report was signed by Registered Nurse employee #3.</p>			

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	<p>Review of the facility Hipaa Policy, undated, on 09-25-12 at 1:45 p.m., indicated the following: "Purpose [bold type and underscored] - To ensure the facility's uses and disclosures of Protected Information (PHI) are limited to the minimum necessary to accomplish the intended purpose."</p> <p>"Types of Violation [bold type]" included "improper protection of medical records or other PHI, failure to properly safeguard or store PHI, careless handling of user names and passwords, and inadequate information security training procedures."</p> <p>"Examples of purposeful violations include: allowing another employee to utilize any systems via your password."</p> <p>7. Review of the "Narcotic Sign Off Sheets," for the two medication carts contained numerous omissions in regard to the required signatures between shifts and</p>			

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	<p>accountability for the nursing staff. In addition the same staff member would sign themselves as the "signing in" staff member as well as the "signed out" staff member.</p> <p>Interview on 09-24-12 at the Exit conference at 3:15 p.m., the Director of Nurses reviewed the narcotic Count Sign Off Sheets and indicated she was unaware the nurses were not completing the document correctly or that the same staff member was signing themselves "in" and "out."</p> <p>The "Controlled Drug Record - Individual Patient's Narcotic Records" for Residents "H", "I", "J", "K", "L", and "M" were reviewed. The record had numerous notations in which the "doses present" had been lined through and the declining dosage changed by handwriting over the typed number and changed to reflect the current count.</p> <p>Interview on 09-24-12 at 3:15 p.m.,</p>			

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	<p>during the Exit Conference, the Director of Nurses indicated she was unaware of the changes made to the "Controlled Drug Record - Individual Patient's Narcotic Records."</p> <p>The directions at the top of the "Narcotic Count Sign Off Sheet," indicated and instructed the nurses as follows:</p> <p>"I the undersigned hereby accept complete responsibility for my signature and the condition of the narcotics that are under double lock on this medication care and inside the locked medication refrigerator. I am aware that a licensed nurse is required by law and facility policy to count the medications (narcotics) at the beginning and at the end of each shift, with another licensed nurse or a Qualified Medication Aide. I am also aware that this facility has two medication carts (i.e. narcotic counts) and that the refrigerator in the locked</p>			

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	<p>medication room must also be counted. As the licensed nurse I am aware that I am responsible for all narcotics for my shift, inside the facility, that a deviance in the narcotic count required immediate notification of the Director of nursing, that the D.O.N. [Director of Nurses] may instruct the licensed nurses to call the police due to the narcotic deviance."</p> <p>Interview on 09-24-12 at 3:15 p.m., during the Exit Conference, the Director of Nurses indicated she was unaware of the omissions to the "Narcotic Count Sign Off Sheet." "The nursing staff never turned these sheets in to me."</p> <p>Review of a "Lynhurst Healthcare" undated policy on 09-25-12 at 2:20 p.m. indicated the following:</p> <p>"Narcotic Count Sign Off Sheet [bold type and underscored] - The nurse or the QMA should understand and hereby accept complete responsibility for</p>						

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	<p>signatures and the condition of the narcotics that are under double lock on this medication cart and inside the locked medication room refrigerator. Be aware that a licensed nurse is required by law and facility policy to count the medications (narcotics) at the beginning and at the end of each shift, with another licensed nurse or a Qualified mediations Aide. Both nurses are to sign the narcotic count sheet. I am also aware that this facility has two medication carts (i.e. narcotic counts) and that the refrigerator in the locked medication room must also be counted. As the licensed nurse I am aware that I am responsible for all narcotics for my shift, inside the facility that a deviance in the narcotic count required immediate notification of the Director of Nursing; that the police are to be called due to the narcotic discrepancy."</p> <p>8. Interview on 09-24-12 at 1:15 p.m., the licensed nurse</p>			

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	<p>representative from the local area Pharmacy indicated she had been called by the facility staff due to the concern of drug diversion. The representative also indicated additional problems with the controlled count sheets, pharmacy manifests and no reconciliation of the drugs and sheets."</p> <p>9. Review of the "Cart Audits Forms," from the local area pharmacy indicated Cart Audits were conducted on January 3, 2012, January 4, 2012, February 6, 2012, March 12, 2012, and July 12, 2012 lacked documentation a reconciliation was conducted, to identify omissions in the narcotic shift count sheet, alteration of the narcotics, possible drug diversion, documentation of error on the controlled drug sheet or PRN medications not documented correctly.</p> <p>Review of the facility policy titled "Lynhurst healthcare - Abuse Prevention," originally dated</p>			

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	<p>12-02-16 and revised 09-17-12 indicated, "Every resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, or volunteers, staff of other agencies servicing the resident, family members or legal guardians, friends or other individuals."</p> <p>"All allegations of abuse are to be reported immediately to the Administrator or her designee: the Director of Nursing."</p> <p>"Types of abuse - Misappropriation of resident property is the deliberate misplacement, exploitation or wrongful (whether temporary or permanent) use of a resident belongings or money without the resident's consent."</p> <p>This Federal tag relates to Complaint IN00115340.</p>			

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F0431 SS=E	<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 observation, record review and interview the facility failed to ensure periodic</p>	F0431	<p>1) What action(s) will be accomplished for those residents found to have been affected? Any resident has the potential to be affected by this deficiency.</p>	10/25/2012			

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	<p>reconciliation of controlled medications, in that when the facility had residents who had physician orders for controlled pain medication, the nursing staff and pharmacy failed to perform random reconciliation of the medications, which led to a determination of drug diversion for 3 of 4 residents [Residents "A", "C" and "D"] and 9 of 9 supplemental sampled residents reviewed. [Residents "E", "F", "G" "H", "I", "J", "K", "L" and "M"].</p> <p>Findings include:</p> <p>1. Interview on 09-24-12 at 8:40 a.m., the Director of Nurses indicated staff from the Attorney Generals office had been "in and out of the facility for the past few weeks investigating drug diversion, which involved at least 3 residents and possibly 4 staff members [employees Registered Nurses employees #3 and #4 and Qualified Medications Aides employees #8 and #9]. "What was happening was</p>		<p>No resident of this facility been noted or reported to have any ill effect regarding this complaint. On 9-06-2012, controlled medication sheets were found to be absent, by the Director of Nursing. The facility immediately contacted all parties required by regulations, including an ISDH report and IMPD. (IE: "turned itself in"), this complaint survey occurred on 9/24 and 9/25, 2012. Once the facility was made aware of the possibility/allegations of an issue with medications, the facility immediately contacted all parties required by regulations, including an ISDH report. Drug test were completed on those staff, in the time frame that was indicated, who had contact with the medication carts. The facility policy is that any staff may be drug tested at random any time and should a positive drug test result, or should an employee refuse a drug test, the employee will be terminated. As a result of those drug tests, three staff members were terminated immediately. The facility now drug tests any new hire nurses and QMA. The alleged drug diversion remains under the scrutiny of the Attorney General's Office Drug Diversion Unit, this facility, the facility's pharmacy and the IMPD. (see exhibit 'I') 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Any resident has the</p>				

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	<p>the nurses were not turning in the controlled sheets to me, so I wasn't aware of what was going on. After I spoke with [name of Qualified Medication Aide employee #8] I started to look at it."</p> <p>Continued interview on 09-24-12 at 9:00 a.m., the Administrator indicated all nursing staff who worked during a specific time frame had been determined, and were sent for drug tests. The Administrator indicated Registered Nurse employee #3 tested positive, while Registered Nurse employee #4 refused the testing. Registered Nurse employee #4 was terminated on 09-09-12 and Registered Nurse employee #3 was terminated on 09-10-12. Testing on Qualified Medication Aide employee #9 also tested positive and was terminated on 09-24-12, while Qualified Medication Aide employee #8 tested negative for drugs.</p> <p>Interview on 09-24-12 at 2:50 p.m.,</p>		<p>potential to be affected by this deficiency. The facility maintains that it does indeed take many varied steps to ensure that misappropriation of resident's property does not occur. The protection of our resident's is our facility's main concern, in all aspects of their care. The facility's policies and procedures have always been in place and are updated frequently. (These policies include misappropriation of resident belongings, drug reconciliation and many more.) Our staff is also in-serviced on facility policy and procedures as per regulations of the state and extensively beyond those regulations. The facility includes 8 video surveillance cameras (now 10 cameras, as of 10/2/2012) in it's ongoing efforts to secure the building and to ensure that misappropriation does not occur. All medication and treatment carts are also stored under surveillance cameras. In our humble opinion, the facility nursing staff did not fail to perform random reconciliation of the medications. Each licensed nurse and QMA (Qualified Medication Aide) goes through an orientation process, once hired by the facility, to ensure that rules and regulations of the medication pass (but not limited to the medication pass) are explained and followed. Licenses and certifications are checked for validity and any</p>		

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	<p>Qualified Medication Aide employee #6 indicated she showed the Director of Nurses a copy of the electronic medication administration record for Resident "C" which indicated by her initials that she dispensed Oxycodone 5/325 mg [milligrams] [a controlled pain medication] to Resident "C", while the Controlled drug sheet clearly showed the medications had been "signed out" by Registered Nurse employee #3. "[Name of Registered Nurse employee #3] came and got the keys to the controlled drugs a lot, if [Registered Nurse employee #3] felt the residents needed the prn [as needed medications], [Registered Nurse employee #3] passed them, under my initials. [Name of Resident "C"] would hardly take routine medications, it was a struggle, let alone the Oxycodone." When further interviewed the Qualified Medication Aide employee #6 indicated with the electronic medication record system, if she had to leave the cart</p>		<p>litigation that is available on the "search and verify" state internet site. The facility is contracted with a pharmacy who provides scheduled audits of all medication carts. These audits take place on a scheduled basis. The results of these audits are then given to the Director of Nursing who follows up on any possible issues. The State of Indiana determined it is appropriate to issue nursing licensures and (Certified) Qualified Medication Aide certificates to those who qualify: and the facility relies on those employees who have been issued such documents by the state, to have the full training and the understanding of their scope of practices regarding medication pass/administration rules and regulations, prior to being hired by this facility. However, the facility's policies and procedures are in place and are updated frequently; our staff is also in-serviced on facility policy and procedures as per regulations of the state and beyond. (see attached) By virtue of a Registered Nursing licensure, a Licensed Practical Nurse licensure and/or a certificate for a Qualified Medication Aide ,(recognized by the Sate of Indiana) and by facility policy, these employees may administer and sign off for narcotic medications. The facility's job description for staff nurses defines the licensed staff duties in</p>				

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	<p>unattended, she would close the lid of the computer. "Now I know we're suppose to log out so no one can document under my password." When interviewed if there were any complaints from the resident's about the pain medications, the Qualified Medication aide indicated "No, because most of the resident's don't know or understand the types of medications that are ordered due to their diagnoses."</p> <p>2. The record for Resident "C" was reviewed on 09-24-12 at 1:00 p.m. Diagnoses included but were not limited to affective psychosis, bipolar disorder, alcohol abuse, cerebral palsy and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order, dated 07-11-12 for Oxycodone-Apap 5/325 mg [milligrams] by mouth every 6 hours as needed for pain.</p> <p>The resident's current plan of care,</p>		<p>detail. (see exhibit 'F'- for licensed staff and exhibit 'G'--for certified staff) The facility requires two licensed staff or a licensed nurse and a Qualified Medication Aide, to sign off on all medications and to take additional precautionary measures with the narcotic count (s). (see attached policies-exhibits A #2 and exhibit B) QMA #6 has been given written council for not signing off on the EZ Mar Medication Pass system when not in direct use and allowing another employee to pass medications under her electronic signature.(see attached) QMA#6 has been re-educated on the basics of the EZ Mar Medication Pass system, including the "LOCK" button on the computer that allows the staff to close out their computer when not in use. This "LOCK" button was included in all nurse and QMA training at the start of the facility utilizing the EZ Mar system. (This information was given to the surveyor who attended this complaint survey/see attached). As per the 9/24/25/2012 survey statement(s): "Further interview...the staff member who identified herself as one of the training staff who came to the facility (for the EZ Mar training)....indicated this function (the LOCK button) was discussed at the training sessions and was contained within the (pharmacy</p>	

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	<p>originally dated 02-06-12 indicated the resident had "actual complaints of pain to left lower leg," and a subsequent plan of care dated 02-09-12 for "headaches on occasion."</p> <p>Review of the electronic medication administration record indicated the resident received the medication on the following dates: August [2012] 1st at 17:12 [5:12 p.m.], August 2nd at 21:46 [9:46 p.m.], August 8th at 15:16 [3:16 p.m.] and 21:39 [9:39 p.m.], August 9th 05:01 [5:01 a.m.], August 11th 08:31 [8:31 a.m.] and 20:53 [8:53 p.m.], August 18 th 19:34 [7:34 p.m.], August 20th 22:03 [10:03 p.m.], August 23rd 18:17 [6:17 p.m.], August 27th 10:08 [10:08 a.m.] and 22:01 [10:01 p.m.], and August 31st 09:21 [09:21 a.m.] 11:12 [11:12 a.m.] and 17:27 [5:27 p.m.] - 15 occasions.</p> <p>Review of the handwritten "Controlled Drug Record - Individual Patient's Narcotic</p>		<p>EZ Mar) handbook." The facility also provided the survey team member with the facility policy regarding HIPPA and electronic information (computers, faxes and the EZMar system) (Please see exhibit E) 3) What measures will be put into place or what systemic changes will be made ? At this time the facility has put additional measures into place for narcotic counts. (Beginning 9-14-2012) A sheet has been added to show the number of bubble packs (medication containers/narcotic card count sheet) that are present on the cart. This sheet also accounts for all bubble packs that are newly delivered or removed from the cart. (see attached) Un-announced narcotic reconciliation counts are done on a weekly basis by the Director of Nursing, the Executive Director or the Assistant Director of Nursing. During these reconciliation counts, the narcotics, the narcotic sign in and sign off sheets are also monitored. The Director of Nursing or her designee is also closely monitoring the Daily Activity Medication Log (see attached) as it is provided to her by the pharmacy. Un-scheduled narcotic counts are also being done on a weekly basis by the DON, ADON or LHFA (LPN). Once per week the DON or ADON will approach the night/day shift nurse to reconcile the daily delivered medication manifests.</p>	

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	<p>Record" indicated the resident received the medication as follows: August 5th at 3:00 a.m., 9:00 a.m. and 3:00 p.m., August 6th at 2:00 a.m., 10:30 a.m., 4:30 p.m., 10:30 p.m., August 7th at 4:30 a.m., 3:30 p.m., and 9:30 p.m., August 8th at 3:00 p.m., and 9:30 p.m., August 9th at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 8:00 p.m., August 10th at 3:00 a.m., August 11th at 8:00 a.m., 2:00 p.m., and 8:00 p.m., August 12 at 3:00 a.m., 10:00 a.m., and 4:00 p.m., August 13th 12:00 a.m., 6:00 a.m., 2:00 p.m., August 14th at 2:00 p.m., August 15th at 6:30 a.m., August 16th at 8:00 a.m., and 2:00 p.m. - 30 occasions.</p> <p>The facility was unable to provide the "Controlled Drug Record - Individual Patient's Narcotic Record," for the remainder of August 2012. Interview with the Director of Nurses on 09-24-12 at 9:00 a.m., indicated "that was part of the problem, the Controlled Drug Records are missing."</p>		<p>(see exhibits B, C, D and exhibit A #2) Pharmacy has been contacted and continues to work with the facility to improve our medications passes and to ensure misappropriation/allegations of, do not occur. Pharmacy is scheduled at this time to complete cart audits of both medication carts, on a monthly basis; including narcotic reconciliation. Pharmacy has also agreed to send a nurse auditor to our facility once a month for the next three months. Continuation of monthly audits after the three month period will be accomplished by a pharmacy technician and the aforementioned changes regarding auditing, by the facility management staff. The facility has also requested an enhancement be done to the EZ Mar electronic Medication system, where the actual # of medication remaining on the medication cart, be accounted for electronically. The Director of Nursing and the Executive Director of the facility will also be attending a seminar offered by NADDIE on October 24th and 25th 2012 on drug diversion in long term care facilities. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? The facility maintains that it does indeed take many varied steps to</p>				

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	<p>Review of the electronic medication administration record for September 1, 2012 thru September 10, 2012 indicated the resident received the medication on 9 occasions, however the "Controlled Drug Record - Individual Patient's Narcotic Record" for the same time period could not be located by facility staff, and a new "Controlled Drug Record - Individual Patient's Narcotic Record," was started for the resident on 09-10-12 which indicated the resident received the medication on 09-12-12 at 5:30 p.m., 09-13-12 at 8:30 p.m., 09-16-12 at 9:00 p.m., and 09-17-12 at 7:00 p.m.</p> <p>However the electronic medication administration record for the time period of September 10, 2012 through September 17, 2012 indicated the resident received the medication on 3 occasions - 09-12-12 at 17:18 [5:18 p.m.], 09-13-12 08:46 [8:46 a.m.] and 09-16-12 at 20:19 [8:19 p.m.].</p>		<p>ensure that misappropriation of resident's property does not occur. In our humble opinion, the facility nursing staff did not fail to perform random reconciliation of the medications. Corrective actions: (IE: additional measures put into place by the facility): A sheet has been added to the medication count to show the number of bubble packs (medication containers/narcotic card count sheet) that are present on the cart. This sheet also accounts for all bubble packs that are newly delivered or removed from the cart. (see attached) Un-announced narcotic reconciliation counts are done on a weekly basis by the Director of Nursing, the Executive Director or the Assistant Director of Nursing. During these reconciliation counts, the narcotics, the narcotic sign in and sign off sheets are also monitored. The Director of Nursing or her designee is also closely monitoring the Daily Activity Medication Log (see attached) as it is provided to her by the pharmacy. Un-scheduled narcotic counts are also being done on a weekly basis by the DON, ADON or LHFA (LPN). Once per week the DON or ADON will approach the night/day shift nurse to reconcile the daily delivered medication manifests. (Please see exhibits 'C' and 'D') Quality assurance : Documentation for all aforementioned paperwork and</p>				

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	<p>3. The record for Resident "A" was reviewed on 09-24-12 at 2:30 p.m. Diagnoses included but were not limited to cancer with metastasis, cellulitis, personality disorder and depression. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders dated 02-12-12 for Oxycodone-Acetaminophen 10-325 two tablets by mouth three times a day as needed for back and leg pain, two tablets by mouth for complaint of severe pain every 6 hours as needed, and one tablet every 6 hours for complaints of moderate pain.</p> <p>The resident's current plan of care originally dated 09-04-09 indicated the resident was at risk for pain related to diabetic neuropathy and history of compression fractures in back, lung cancer, and arthritis."</p> <p>Interview on 09-24-12 at 2:50 p.m.</p>		<p>paperwork checks, are monitored by the Director of Nursing or the ADON. The aforementioned changes are assigned no stop date and will continue at the least for the next 6 (six) months; at that time the efficiency of these paperwork changes will be re-evaluated. All paperwork/monitoring forms etc, will be discussed in a monthly Quality Assurance meeting. The Director of Nursing will maintain a log on this paperwork and the discussions during the facility's QA meetings. Quality assurance : New employees who are licensed or certified by the State of Indiana to administer medications will be drug tested upon hire or within 30 (thirty) days of hire. The facility drug testing policy will be adhered to and this will have no stop date. The LHFA will maintain and monitor the drug test results . Positive employee drug tests will be immediately reported to the ISDH, 5) By what date will the corrections be completed? October 25th, 2012</p>		

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	<p>Qualified Medication Aide employee #8 indicated the resident requested the pain medication every morning usually "around 6:00 a.m."</p> <p>Review of the electronic medication administration record for August 2012 indicated the resident received the medication on August 2nd 04:50 [4:50 a.m.], 07:28 [7:28 a.m.], 21:45 [9:45 p.m.], August 3rd 07:46 [7:46 a.m.], August 5th at 05:08 [5:08 a.m.] and 07:08 [7:08 a.m.], August 6th 04:57 [4:57 a.m.], August 7th at 05:05 [5:05 a.m.], August 8th 15:17 [3:17 p.m.], August 9th 04:47 [4:47 a.m.], August 10th 16:02 [4:02 p.m.], August 11th 01:35 [1:35 a.m.], August 12th 05:50 [5:50 a.m.], August 13th 05:07 [5:07 a.m.] and 08:08 [8:08 a.m.], August 14th 04:56 [4:56 a.m.], and 07:38 [7:38 a.m.], August 16th 05:09 [5:09 a.m.], August 20th 21:22 [9:22 p.m.], August 22 06:07 [6:07 a.m.], August 25th 15:28 [3:28 p.m.], August 27th 21:41 [9:41 p.m.], and August 31st 17:14 [5:14</p>			

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	<p>p.m.] - 23 occasions.</p> <p>A request was made to review the "Controlled Drug Record - Individual Patient's Narcotic Record," for the month of August 2012. The facility was unable to provide the documentation for review.</p> <p>4. The record for Resident "D" was reviewed on 09-25-12 at 9:30 a.m. Diagnoses included but were not limited to dementia with agitation, depression, mild mental retardation, neuropathy, paranoia and delusions. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order dated 05-03-12 for Hydrocodone-Acetaminophen 5-500 2 tablets every 4 hours as needed for moderate pain or severe pain as needed.</p> <p>The resident's current plan of care, originally dated 02-26-12 indicated the resident "is at risk for pain</p>						

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	<p>related to complaints of bilateral knee pain and diagnosis of neuropathy."</p> <p>Review of the electronic medication administration record for August 2012 indicated the resident received the medication on August 1st 17:29 [5:29 p.m.], August 6th 04:39 [4:39 a.m.] and again at 19:28 [7:28 p.m.], August 9th 04:25 [4:25 a.m.], August 11th 08:17 [8:17 a.m.], August 13th 08:16 [8:16 a.m.], August 26th 21:21 [11:21 p.m.], August 27th 00:41 [12:41 a.m.], and August 31st 14:29 [2:29 p.m.] - 9 occasions.</p> <p>Review of the "Controlled Drug Record - Individual Patient's Narcotic Record," for August 2012 indicated the resident received the medication as follows: August 4th at 2:30 p.m., August 5th at 3:00 a.m., August 6th at 5:30 a.m., and 8:30 p.m., August 7th 5:00 a.m., and 5:00 p.m. [three tablets], August 9th 5:00 a.m., 10:00 a.m.,</p>			

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	<p>and 2:00 a.m. and 6:00 p.m., August 12th 5 a.m., 3:30 p.m., and 8:00 p.m., August 13th at 8:00 a.m., August 14th 9:30 a.m., and 1:30 p.m., August 16th at 7:00 a.m., 11:00 a.m. and 3:00 p.m., August 18 th 2:00 a.m., 8:00 a.m., and 1:00 p.m., August 19th 1:00 a.m., August 20th 10:00 a.m., 2:00 p.m., August 24 4:00 a.m., 9:00 a.m., and 3:00 p.m., August 28th 4:00 a.m., August 29th 9:00 a.m., August 31, 6:00 a.m. and 10:00 a.m. - 32 occasions.</p> <p>Review of the electronic medication administration record for September 2012 indicated the resident did not receive any of the prescribed medication, however review of the "Controlled Drug Record - Individual Patient's Narcotic Record," for September 2012 indicated the resident received the medication on 09-01-12 at 4:00 a.m., 8:00 a.m., 12:00 p.m., and 09-03-12 at 5:00 a.m. - 4 occasions.</p>			

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	<p>5. Observation on 09-24-12 at 1:30 p.m., Licensed Practical Nurse employee #10 was standing at the medication carts. A request was made to reconcile the controlled prn [as needed] medications for the residents. The nurse requested the keys for the medication carts from Qualified Medication Aide employee #8. The nurse unlocked the cart and then unlocked the secured controlled box which was contained within the medication cart.</p> <p>There were 3 supplemental sampled residents [Resident's "E", "F" and "G"] medications reviewed in addition to the sampled residents. The reconciliation of all medications was accurate with the exception of Resident "E" who's actual medication package observed were 57 tablets of Hydrocodone 3-325 mg and the "Controlled Drug Record - Individual Patient's Narcotic Record," for September 2012 indicated the "count" was 58.</p>			

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	<p>Interview on 09-24-12 at 1:40 p.m., Licensed Practical Nurse employee #10 indicated the QMA [Qualified Medication Aide] employee #8 "probably forgot to sign the med. [medication] out."</p> <p>Interview on 09-24-12 at 2:00 p.m., Qualified Medication Aide employee #8 returned to the medication cart and indicated she "forgot to sign out" the medication for Resident "E."</p> <p>Interview on 09-24-12 at 2:50 p.m., the QMA indicated she had "not yet" signed out the medication for the resident.</p> <p>6. Observation on 09-24-12 at 2:15 p.m., all three computers attached to the medication and treatment carts had the lids open. When interviewed if anyone could chart under another persons password, Licensed Practical Nurse employee #10 indicated she didn't know. The Licensed Nurse placed her fingertip onto the mouse pad and the</p>						

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	<p>computer "opened" to a medication record and the computer screen indicated the "user" was QMA employee #8. The additional two computer mouse pads were touched and the computer screen appeared with a resident medication record and the "current user." During interview the Licensed Practical Nurse indicated she was unaware of how to secure the computer so entry by an unauthorized person could be attempted. "I usually sign out the entire way and then when I have to get into the computer I sign back in."</p> <p>Interview on 09-25-12 at 8:45 a.m., a representative from the local area Pharmacy indicated when a staff member leaves the vicinity of the computer, the staff member needs to press the "lock" key, and then upon return, touch the mouse pad and the user will be prompted to enter their password. Further interview the staff member who identified herself as one of the</p>						

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	<p>training staff who came to the facility to train the nurses and Administrative staff last October [2011] indicated this function was discussed at the training sessions and was contained within the handbook.</p> <p>Interview on 09-25-12 at 9:30 a.m., the Director of Nurses indicated she was unaware of the "lock" function. Additional interview on 09-25-12 at 9:15 a.m., Licensed Practical Nurse employee #10 indicated she was not aware of the "lock" function to protect the electronic medication administration record.</p> <p>Interview on 09-25-12 at 2:40 p.m., the Assistant Director of Nurses indicated she was not trained on the "lock" function of the electronic medication administration record.</p> <p>Interview on 09-25-12 at 3:00 p.m., the Administrator indicated the Easy Mar [electronic medication administration record] handbook did not contain information in regard to the "lock" function.</p>						

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	<p>Review of an "Unsatisfactory Work Report," dated 08-29-12 in regard to Registered Nurse employee #3 indicated the following: "PRN narcotics are given to resident and signed out for controlled drug record, however several are not documented on the MAR [medication administration record] and/or the nurses notes. Facility policy states that PRN medications <sic> are to be assessed by the nurse, rated on a scale to 1-10 (10 being the worst) and re-evaluated for effectiveness and rated from 1-10. Not only is this a violation of policy, it also presents an unclear picture of frequency of pain. Also discussed signing out meds given by someone else and signing out meds under another employees computer ID [identification]. This employee report was signed by Registered Nurse employee #3.</p> <p>Review of the facility Hippa Policy, undated, on 09-25-12 at 1:45 p.m., indicated the following: "Purpose</p>			

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	<p>[bold type and underscored] - To ensure the facility's uses and disclosures of Protected Information (PHI) are limited to the minimum necessary to accomplish the intended purpose."</p> <p>"Types of Violation [bold type]" included "improper protection of medical records or other PHI, failure to properly safeguard or store PHI, careless handling of user names and passwords, and inadequate information security training procedures."</p> <p>"Examples of purposeful violations include: allowing another employee to utilize any systems via your password."</p> <p>7. Review of the "Narcotic Sign Off Sheets," for the two medication carts contained numerous omissions in regard to the required signatures between shifts and accountability for the nursing staff. In addition the same staff member would sign themselves as the</p>						

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	<p>"signing in" staff member as well as the "signed out" staff member.</p> <p>Interview on 09-24-12 at the Exit conference at 3:15 p.m., the Director of Nurses reviewed the narcotic Count Sign Off Sheets and indicated she was unaware the nurses were not completing the document correctly or that the same staff member was signing themselves "in" and "out."</p> <p>The "Controlled Drug Record - Individual Patient's Narcotic Records" for Residents "H", "I", "J", "K", "L", and "M" were reviewed. The record had numerous notations in which the "doses present" had been lined through and the declining dosage changed by handwriting over the typed number and changed to reflect the current count.</p> <p>Interview on 09-24-12 at 3:15 p.m., during the Exit Conference, the Director of Nurses indicated she was unaware of the changes made</p>						

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	<p>to the "Controlled Drug Record - Individual Patient's Narcotic Records."</p> <p>The directions at the top of the "Narcotic Count Sign Off Sheet," indicated and instructed the nurses as follows:</p> <p>"I the undersigned hereby accept complete responsibility for my signature and the condition of the narcotics that are under double lock on this medication care and inside the locked medication refrigerator. I am aware that a licensed nurse is required by law and facility policy to count the medications (narcotics) at the beginning and at the end of each shift, with another licensed nurse or a Qualified Medication Aide. I am also aware that this facility has two medication carts (i.e. narcotic counts) and that the refrigerator in the locked medication room must also be counted. As the licensed nurse I am aware that I am responsible for</p>				

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	<p>all narcotics for my shift, inside the facility, that a deviance in the narcotic count required immediate notification of the Director of nursing, that the D.O.N. [Director of Nurses] may instruct the licensed nurses to call the police due to the narcotic deviance."</p> <p>Interview on 09-24-12 at 3:15 p.m., during the Exit Conference, the Director of Nurses indicated she was unaware of the omissions to the "Narcotic Count Sign Off Sheet." "The nursing staff never turned these sheets in to me."</p> <p>Review of a "Lynhurst Healthcare" undated policy on 09-25-12 at 2:20 p.m. indicated the following:</p> <p>"Narcotic Count Sign Off Sheet [bold type and underscored] - The nurse or the QMA should understand and hereby accept complete responsibility for signatures and the condition of the narcotics that are under double lock on this mediation cart and inside</p>			

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	<p>the locked medication room refrigerator. Be aware that a licensed nurse is required by law and facility policy to count the medications (narcotics) at the beginning and at the end of each shift, with another licensed nurse or a Qualified mediations Aide. Both nurses are to sign the narcotic count sheet. I am also aware that this facility has two medication carts (i.e. narcotic counts) and that the refrigerator in the locked medication room must also be counted. As the licensed nurse I am aware that I am responsible for all narcotics for my shift, inside the facility that a deviance in the narcotic count required immediate notification of the Director of Nursing; that the police are to be called due to the narcotic discrepancy."</p> <p>8. During interview on 09-25-12 at 9:15 a.m. Licensed Practical Nurse employee #10 indicated she did not have the keys to the controlled drugs, "the QMA has those." When</p>			

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	<p>further interviewed the reasoning why the licensed nurse did not have possession of the narcotics keys, the licensed nurse and the Director of Nurses indicated "because the QMA gives the medications."</p> <p>Review of facility policy on 09-24-12 at 1:00 p.m., and dated 09/08 indicated the following:</p> <p>"Controlled Medication Storage" [bold type] Medications included in the state and federal Drug Enforcement Administration (DEA) classified as controlled substances are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations."</p> <p>"Procedures" [bold type]" 1. The director of nursing and the consultant pharmacist monitor for compliance with federal and state laws and regulations in the handling of controlled medications.</p>			

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	<p>2. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. The medication nurse on duty maintains possession of the key to controlled medication storage areas. 6. At each shift change or when keys are rendered, a physical inventory of all Schedule 2 controlled medications is conducted by two licensed nurses or per state regulations and is documented on the controlled substances accountability record or verification of controlled substances count report. 7. Any discrepancy in controlled substance medication counts is reported to the director of nurses immediately. The director of nursing or designee investigates and makes every reasonable effort to reconcile all reported discrepancies while nurses remain on duty. The director of nursing in a report to the administrator, documents irreconcilable discrepancies. 8. Current controlled medication accountability records are kept in</p>			

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	<p>MAR or narcotic book. When completed, accountability records are submitted to the director of nursing and maintained on file at the nursing care center."</p> <p>9. Interview on 09-24-12 at 1:15 p.m., the licensed nurse representative from the local area Pharmacy indicated she had been called by the facility staff due to the concern of drug diversion. The representative also indicated additional problems with the controlled count sheets, pharmacy manifests and no reconciliation of the drugs and sheets."</p> <p>10. Review of the "Cart Audits Forms," from the local area pharmacy indicated Cart Audits were conducted on January 3, 2012, January 4, 2012, February 6, 2012, March 12, 2012, and July 12, 2012 and lacked documentation a reconciliation was conducted, to identify omissions in the narcotic shift count sheet, alteration of the narcotics, documentation of error</p>						

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	<p>on the controlled drug sheet or PRN medications not documented correctly.</p> <p>Interview on 09-25-12 at 9:00 a.m., the Administrator indicated her "understanding was the Pharmacy representative was to come to the facility on a monthly basis and include in the cart audit a review of the narcotics."</p> <p>The Administrator indicated when she telephoned the Pharmacy representative on 09-24-12, the pharmacy understanding was the Administrator changed the frequency of the cart audits to quarterly. The Administrator indicated this was not her understanding, and that during the previous months the pharmacy representative should have been checking the narcotics/controlled medications.</p> <p>11. On 09-24-12 at 12:45 p.m., the Administrator provided a "Pharmacy Services Agreement"</p>				

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	<p>dated 10-18-02. Review of the Consulting Services and pricing - Hourly" agreement indicated "(k) Twice yearly provide a consulting pharmacist or nurse to conduct an operational review of Owner's facilities."</p> <p>On 09-25-12 at 1:00 p.m., the Administrator indicated a subsequent pharmacy agreement, provided by the Pharmacy, dated 08-06-07 lacked the above Consulting Services Agreement."</p> <p>Interview on 09-25-12 at 1:15 p.m., the Administrator indicated she was unaware of the change to the Agreement.</p> <p>This Federal tag relates to Complaint IN00115340.</p> <p>3.1-25(b)(3) 3.1-25(b)(4) 3.1-25(b)(9) 3.1-25(e)(2) 3.1-25(e)(3)</p>						