

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/30/2014
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NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00142592.</p> <p>Complaint IN00142592 substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 22, 23, 24, 27, 28, 29, & 30, 2014</p> <p>Facility number: 000476 Provider number: 155446 AIM number: 100290870</p> <p>Survey team: Sue Brooker RD TC Martha Saull RN Julie Call RN (January 22, 23, & 24, 2014) Angela Strass RN (January 23, 24, 27, & 28, 2014) Virginia Terveer RN (January 27, 28, 29, & 30, 2014)</p> <p>Census bed type: SNF/NF: 113 Total: 113</p> <p>Census payor type:</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000224 SS=D	<p>Medicare: 12 Medicaid: 73 Other: 28 Total: 113</p> <p>These deficiencies reflect state findings cite in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 5, 2014 by Randy Fry RN.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 interview and record review, the facility failed to ensure resident's controlled substances (narcotic medications) were not misappropriated for 2 of 9 residents reviewed for narcotic controlled substance reconciliation. Resident #230, Resident #234</p> <p>Findings include:</p> <p>1. On 1/29/14 at 4:11 P.M., the Nurse</p>	F000224	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.#1 Medication carts on units</p>	02/21/2014			

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	<p>Consultant provided a current facility policy and procedure for "Safeguarding Controlled Substances." This policy was dated 1/09. The policy included, but was not limited to, the following: "Practice: Each facility will engage in safe and secure practices related to appropriately receiving, storing, administering, reconciling and safeguarding controlled substances...Administration of controlled medications: The licensed nurse is to immediately enter the following information when removing dose(s) from controlled storage on the resident's individual controlled substance accountability record:...amount of medication remaining, signature of nurse removing the medication; Following removal and administration, the nurses is (sic) to document on the residents MAR (medication administration record) the date, time, and reasons (if PRN (as needed) a controlled substance had been given; Following removal of dose(s) which were not administered for whatever reason; the medication must be destroyed (wasted) by 2 Licensed Nurses per policy disposal procedure; both nurses must witness and sign to legally attest the destruction. Reason for the disposal should accompany the signatures, such as "dose refused"..on the control accountability record on the line representing that dose and signed by both</p>		<p>containing PRN Narcotics were counted immediately on 1/23/2014. In addition Residents #234 and #230 PRN. Corrections were made immediately during the survey. #2 A narcotic audit was completed on residents receiving PRN narcotics on 1/31/2014. #3 Licensed nursing staff were inserviced immediatley on the proper policy and procedure for administration, counting, and documentation on 1/23/2014. Licensed nursing staff to be re-inserviced on 2/25/2014 on the proper administration, counting, and documentation of PRN narcotics based upon company's policy and procedure and state and federal regulations. #4 UM/ Designee will audit PRN Contolled Substance Sheets, shift to shift narcotic count sheets, and Administration records for completion, 5 times weekly for 4 weeks, then one time a week times 1 month, thereafter monthly times 3 months. Pharmacy Tech will continue to do random checks on a quarterly basis to continue to audit for compliance. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months. #5 Systematic changes will be completed 3/1/2014.</p>	

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	<p>licensed nurses. Do Not Replace back into the container or package; Controlled Drug Count/Change-of-shift Reconciliation: Each individual controlled substance must be counted when there is a change in shift nurse; The on-coming licensed nurse will view and verify each medication supply and amount(s) remaining, while the off-going nurse calls out the resident name, medication and amounts remaining on controlled logs. The count should be completed in a diligent manner and the oncoming nurse should examine tablets and medications carefully during the count...Both on-coming and off-going licensed nurses will sign the controlled drug count verification form when deemed accurate. At this time, the on-coming nurse may assume the keys.</p> <p>On 1/29/14 at 11:51 A.M., the DON provided copies of Resident #234's medication card (med card) (from the controlled substance portion of the medication cart) for Oxycodone-APAP 5/325mg (Schedule II controlled substance)and the controlled substance record for this medication. The Physician order on the front of the card indicated the following: "Give 1-2 tablets...every 4 hours as needed for pain." From the front of this card, there were 25 pills on the med card. The back of the card had a</p>			
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	<p>piece of tape which covered the broken paper seal to pill #27. The same piece of tape, partially covered the broken paper seal for pill #26. Neither pill #26 or #27 were observed in the med card at the time.</p> <p>At the time, the controlled substance record for the medication was reviewed and indicated the following: On 1/27/14 at 12 A.M., 2 pills were signed out by RN #14. On 1/27/14 at 7:50 A.M., 1 pill had been signed out, quantity remained was 27.</p> <p>The following 4 entries had been documented by RN #14 but the all the entries, had been crossed through with "ER" (error) written beside RN#14's initials:</p> <p>1/27/14 at 11 P.M. 1 pill; qty (quantity) remained of 26; 1/27/14 at 10 P.M. (sic) 1 pill; qty remained of 25; 1/28/14 at 2 A.M. 1 pill; qty remained of 24; 1/28/14 at 6 A.M. 1 pill; qty remained of 26 (sic); 1/29/14 at 11:10 A.M. 2 pills wasted due to package opened, 25 pills remained. This entry was witnessed by two nurse, one being the Unit Manager of the Rehab unit.</p>			

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	<p>On 1/29/14 at 11:52 A.M., LPN #9 was interviewed. She indicated the following: At the beginning of her shift on 1/28/14, she counted narcotics with RN #14. She indicated during the shift change count, RN #14 had counted the controlled substance log and she (LPN #9) had counted the medication cards. LPN #9 indicated at the time, she noticed the sticker over the back of pill #27 on Resident #234's card of Oxycodone. She indicated there was a pill in the #27 slot that looked like the other, unopened pills on the card. LPN #9 indicated, that today, the Unit Manager of the Rehab Unit, disposed of pill #27 and #26 today from the oxycodone controlled substance card. At the time, the DON indicated the areas left blank on the nursing narcotic reconciliation log, were due to nurses working over 8 hour shifts. She indicated nurses only count the carts when they are done working on a cart.</p> <p>On 1/29/14 at 4 P.M., the MAR and Controlled Substance sign out logs for January 2014 were reviewed for Resident #234. The following observations were made: from the dates of 1/8/14 - 1/25/14, there were a total of 37 entries on the controlled substance record to sign out medications. Of the 37 narcotic log entries, 22 of the signed out narcotic oxycodone doses were not documented as</p>			

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	<p>given and/or refused on the MAR.</p> <p>On the date of 1/15/14, documentation on the MAR indicated Resident #234 was medicated at 7:40 A.M. with oxycodone 5 mg-325 mg, 1 tablet. Documentation was lacking on the controlled substance record that this medication had been signed out for her.</p> <p>On 1/30/14 at 9:30 A.M., the DON provided a copy of LPN #9's interview. This form included, but was not limited to, the following: Narcotic counts not correct, pill sitting on med (medication) cart when (LPN #9's name) came on shift...When I (LPN #9) came on shift, (RN #14 name) was at med cart. When we were ready to do count, I saw a white pill in a cup on the cart. I asked (RN #14 name) what the pill was and who it was for. (RN #14 name) said it was for (Resident #234 name). (RN #14 name) said that (Resident # 234 name) asked for one. I offered to give it to resident when I passed meds. When I went in (Resident # 234) room, she asked me why was there a pain pill. I asked did you not ask (RN #14 name) for one and she answered "no." Went back to cart and (RN #14) took pill and taped pill back into the card." The DON signed this form as the interviewer on 1/28/14.</p>			

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	<p>On 1/30/14 at 8:50 A.M., the DON was interviewed regarding the taped medication cards for Resident #234. She indicated the following: LPN #9 and RN #14 counted the narcotics the morning of 1/29/14 at the 7 A.M. shift change. She indicated LPN #9 was the day shift nurse coming on duty and RN #14 was the night shift nurse going off duty. The DON indicated when LPN #9 counted the narcotics, she saw tape was on the back of the medication card over broken paper seals for pills number #27 and #26 and LPN #9 indicated there were pills in the both of these broken paper seals.</p> <p>At the time, the DON was interviewed regarding having accounted for the narcotics that were signed out from the controlled substance log but were not documented as given on the MAR. She indicated they were still investigating the situation. The DON indicated at this time, narcotics signed out on the Controlled Substance log should match the entries on the MAR, regarding administration, refusal, date and time.</p> <p>2. On 1/29/14 at 10:20 A.M., copies of Resident # 230's MAR and controlled substance log for the narcotic medication Hydrocodone-APAP 5-325 mg were received from the DON. The MAR indicated the following physician order:</p>						

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	<p>"Give 1-2 tablets...every 4 hours as needed for pain." The Controlled substance log indicated the following:</p> <p>A. On 1/17/14 at 2 P.M., a quantity of 24 was documented. On 1/17/14 at 6 P.M., two pills were signed out and a quantity of 24 (sic) pills were documented. On 1/16/14 at 11:55 P.M., the CSR indicated 2 pills of hydrocodone had been signed out but the MAR indicated for 1/16/14 at 11:30 P.M., 1 pill of hydrocodone was administered to Res #230.</p> <p>B. On 1/17/14 at 7:53 A.M., the MAR indicated the resident refused 1 pill of hydrocodone. The CSR is lacking documentation of the medication being signed out.</p> <p>C. The following dates and times were documented on the CSR but documentation was lacking on the MAR that the medication had been given to Resident #230: 1/17 at 2 P.M. and 6 P.M.; 1/18 at 12 A.M.; 1/19 at 4 P.M. and 8 P.M.; 1/20 at 3:30 A.M.; 1/21 at 12:30 A.M.; 1/22 at 11 P.M.; 1/23 at 3 A.M.; 1/26 at 2 A.M. and 1/27 at 4 A.M.</p> <p>D. A dose documented as given on the MAR on 1/22 at 12:28 P.M. lacked documentation on the CSR of having been signed out.</p>			

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	<p>On 1/30/14 at 8:37 A.M., the DON was interviewed. She indicated the facility was in the beginning stages of the investigation of the discrepancy with narcotics. She indicated the Rehab unit was the biggest concern and this was where they started their investigation. She indicated they had reconciled the drugs on the rehab unit and the narcotics as to what had and had not been documented. She indicated she had looked for patterns. She indicated this was as far as they got last night. The DON indicated they found some inconsistencies and some things they need to work on. The DON indicated they have issues that need to be corrected and they will take longer than one night to investigate. At the time, the DON was unable to account for the medications which had been signed out from the CSR but not documented as given.</p> <p>Documentation was lacking to indicated Resident #230 received the schedule III controlled substance medication which had been signed out from the CSR for him but were not documented as given to him on the MAR.</p> <p>3.1-27(b)</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his</p>				

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	<p>designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report immediately to the state agency discrepancies between the controlled substance records and the MARs (medication administration records) indicating possible misappropriation of resident's narcotic medications for 1 of 9 resident's reviewed who received narcotic medications. Resident #74</p> <p>Findings include:</p> <p>On 1/29/14 at 4:40 P.M., the Nurse Consultant, provided the controlled substance record and MAR (Medication Administration Record) for Resident #74. For the time frame of 1/2/14 to 1/29/14, the Controlled Substance Record (CSR) had documented the resident had 12 pills of Hydrocodone-APAP 5-325 mg signed out. When the CSR was compared to the MAR, there were 5 pills that were signed out on the CSR but were not accounted for and documented as given on the MAR.</p> <p>On 1/30/14 at 10 A.M., the DON</p>	F000225	<p>#1 The facility reported a possibility of missing medications on 1/30/2014 with completed follow-up report sent on 2/4/2014. #2 A narcotic audit was completed on residents receiving PRN narcotics on 1/31/2014. No other issues identified.#3 ED and DON will be educated on the ISDH reporting guidelines by the RDCO.#4 ED/ Designee will randomly audit PRN Controlled Substance Sheets, shift to shift narcotic count sheets, and Administration records for completion, daily times 4 weeks, then one time a week times 3 months, then one time a month for 3 months for any unexplained discrepancies. Pharmacy Tech will continue to do random checks on a quarterly basis to continue to audit for compliance. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months. #5 Systematic changes will be completed 3/1/2012.</p>	03/01/2014

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	<p>(Director of Nursing) was interviewed regarding her investigation of the discrepancy of the Tramadol with Resident #74 on 1/23/14. She indicated the nurse, LPN #13, had signed the medication Tramadol 50mg off of the Controlled Substance log on 1/23/14 at 2 P.M. (leaving 25 pills on the log) but had not removed the pill from the medication card (leaving 26 pills on the card). The DON indicated LPN #13 documented (on the MAR) the medication was administered to the resident on 1/23/14 at 2 P.M.</p> <p>On 1/30/14 at 2 P.M., the Nurse Consultant provided a current copy of the facilities policy and procedure for "Reportable Incidents Policy." This policy was revised 1/15/13 and is from the ISDH. The purpose of the policy indicated "to ensure that reportable incidents are recorded and monitored to facilitate compliance with state and federal laws....The initial report should contain: A brief description of the occurrence; any injury sustained by a resident; a description of the action taken by the facility to respond to the situation; action taken by the facility to prevent further occurrence while investigation is in progress; A five (5) day follow-up report is required to include the following: results of the investigation;</p>			
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	<p>plan of action /interventions implemented to prevent similar occurrences; to include corrective actions taken; method in which facility will continue to monitor efficacy of interventions; other persons or agencies to whom incident was reported..."</p> <p>At the time, the Administrator, DON (Director of Nursing) and Nurse Consultant were interviewed. The DON indicated the facility was aware they had nurses who were not documenting administration of narcotic medications the way they were supposed to. She indicated they were aware they have a documentation issue. The Corporate Nurse indicated they are continuing to investigate the issues regarding the discrepancies with the narcotics but she doesn't think they have a reportable issue at this time. She indicated she can't say whether they have narcotic medications missing or not. The Nurse consultant indicated they are not able to identify where the narcotics that were signed off the controlled substance logs and not documented on the resident's medication administration record were accounted for. She indicated the facility is continuing to investigate this issue.</p> <p>3.1-28(c)</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</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 interview and record review, the facility failed to follow their policy and procedure in regards to reporting an unusual occurrence to the Indiana State Department of Health regarding discrepancies in narcotic controlled substance reconciliation indicating possible misappropriation of narcotic medications.</p> <p>Findings include:</p> <p>On 1/30/14 at 2 P.M., a copy, of the "Reportable Incidents Policy" was received from the Nurse Consultant. This policy was revised 1/15/13 and is from the ISDH. The purpose of the policy indicated "to ensure that reportable incidents are recorded and monitored to facilitate compliance with state and federal laws." The policy also included, but was not limited to, the following: all incidents reported to the Indiana State Department of Health will be recorded</p>	F000226	<p>#1 The initial report was sent to ISDH on 1/30/2014. The final and follow-up to the initial report with substantiated findings were sent to ISDH 2/4/2014. #2 Medication carts were counted immediatley on 1/23/2014. A narcotic audit was completed on residents receiving PRN narcotics on 1/31/2014. #3 The ED and the DON will be educated on what constitutes a reportable occurrence to the ISDH and the guidelines when and how to report.#4 ED /designee will randomly review Controlled Substance Sheet Audits for any discrepancies that may need to be reported. ED will review weekly times 4weeks, monthly for 2 months. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months. #5 Systematic changes will be completed 3/1/2/0124.</p>	03/01/2014

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	<p>and tracked or monitored to insure residents are receiving appropriate care and services."</p> <p>At the time, the Administrator, DON (Director of Nursing) and Nurse Consultant were interviewed. The DON indicated the facility was aware they had nurses who were not documenting administration of narcotic medications the way they are supposed to. She indicated they were aware they have a documentation issue. The Corporate Nurse indicated they are continuing to investigate the issues regarding the discrepancies with the narcotics but she doesn't think they have a reportable issue at this time. She indicated she can't say they have narcotic medications missing or not. The Nurse consultant indicated they are not able to identify where the narcotics that were signed off the controlled substance logs and not documented on the resident's medication administration record were accounted for. She indicated the facility is continuing to investigate this issue.</p> <p>3.1-28(c)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to initiate a fall risk care plan for 1 of 6 residents (Resident #224) reviewed for falls.</p> <p>Findings include:</p> <p>The record review began on 1-27-2014 at 2:07 p.m.</p> <p>Diagnoses included but were not limited</p>	F000279	<p>#1 Resident # 224's care plan was reviewed and updated to reflect her outcomes of her Fall Risk Assessment on 1/28/2014.#2 Facility will audit residents which are at risk for falls to be sure careplan is in place as appropriate. #3 Licensed staff will be inserviced on 2/25/2014 on completing the Fall Risk assessments and creating a comprehensive care plan based on the outcomes of the assessment and any</p>	03/01/2014

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	<p>to, a pelvis fracture, joint pain-pelvis, intermediate coronary syndrome, constipation, hypertension, esophageal reflux, depressive disorder, lumbago (lower back pain) and dysphagia (difficulty swallowing).</p> <p>A review of the history and physical from Lutheran Hospital dated 12-11-2013 indicated the resident sustained a fall at home and fractured her pelvis and left wrist. Resident #224 was admitted to the facility on 12-17-2013.</p> <p>A review of the initial nursing assessment completed on 12-17-2013, indicated the resident had a history of falls within the last 30 days and the fall resulted in a fracture.</p> <p>A review of the Fall Risk Evaluation dated 12-17-2013 indicated a score of 12 ("If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.")</p> <p>A review of the Social Service Assessment completed on 12-24-2013 indicated a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated resident was cognitively intact) and the 14 day assessment done on 12-31-2013</p>		<p>interventions care planned and put into place.#4 UM/ Designee will audit new admits to ensure Fall Risk Care Plans are developed as appropriate. Fall Risk Care Plans will be audited 5 times a week, then 1 time weekly for a month, then monthly times 3 months. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months. #5 Systematic changes will be complete by 3/1/2014.</p>		

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	<p>indicated a BIMS score of 15/15.</p> <p>A review of the nurse's notes dated 1-11-2014 indicated Resident #224 slipped out of bed at 5:15 a.m. A review of the MAR (Medication Administration Record) indicated on 1-11-2014 at 7:04 a.m., the resident had bone pain rated a "6" out a "10". (A "6" indicated moderate pain.) At 10:05 a.m., Resident #224 complained of right hip pain. An order for a hip/pelvic X-ray was received.</p> <p>A review of the X-ray report dated 1-11-2014 indicated "age indeterminate fractures of the superior and inferior left pubic rami....the hip joints...were without fracture."</p> <p>A review of Resident #224's record indicated a "Fall Risk Care Plan" was not initiated.</p> <p>An interview with RN #7 on 1-28-2014 at 10:59 a.m., indicated Resident #224 should have had a "Fall Risk Care Plan" at admission due to a fall risk score of 12.</p> <p>A policy "Falls Management" dated October 2010 was provided by the Corporate Nurse on 1-30-2014 at 2:00 p.m., indicated for the "Fall Prevention Procedure" to "evaluate risk factors for sustaining falls upon admission...initiate</p>			

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F000282 SS=D	<p>a fall prevention care plan...."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow the Clinical Dietician's recommendations for 2 of 5 residents (Residents #136 and #224) identified as being underweight and not receiving a supplement who met the criteria for weight loss. The facility also failed to ensure dietary recommendations made by the dietitian were implemented as ordered for 1 of 1 resident reviewed for dialysis. (Resident #230)</p> <p>Findings include:</p> <p>1. The record review for Resident #136</p>	F000282	#1 Resident's #136, #224, and #230 their dietary recommendations were reviewed and were written to be approved and signed off as an order by the Physician/ NP.#2 Dietary recommendations for the past 3 months will be reviewed and audited to verify recommendations were put into affect. Recommendations not implemented will be reviewed by the RD for appropriateness and written accordingly. #3 Licensed nurses will be inserviced on how to process a dietary recommendation. #4 UM/designee will monitor dietary recommendations to make sure	03/01/2014	

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	<p>began on 1-27-2014 at 11:27 a.m. The diagnoses included but were not limited to, COPD (chronic obstructive pulmonary disease), pain in limb, insomnia, esophageal reflux, depression and chronic pain.</p> <p>Review of current physician orders indicated a regular diet with regular consistency.</p> <p>Weights recorded as follows: 8-1-13 123 lbs (pounds) 9-3-13 120 lbs 10-1-13 125 lbs 11-2-13 126 lbs 12-3-13 128 lbs 1-2-13 131 lbs</p> <p>A review of the dietary assessment dated 6-4-2013 indicated Resident #136 had a BMI (body mass index which is a measure of body fat) of 21. The ideal body weight identified by the dietician was 135 lbs.</p> <p>A review of the nutritional progress notes dated 8-6-2013 indicated Resident #136 had a 6.7% weight loss in 30 days. The dietician's recommendations were for "weekly weights x 4 to monitor...."</p> <p>An interview with LPN #1 on 1-27-2014 at 1:36 p.m., indicated Resident #136 had</p>		<p>they are completed weekly. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months. #5 Systematic changes will be completed by 3/1/2014.</p>		

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	<p>been only weighed monthly.</p> <p>An interview with the CDM (Certified Dietary Manager) on 1-28-2013 at 11:02 a.m., indicated the process for the "RD Recommendation Form" was to give the recommendations to the unit managers, DON (Director of Nursing) and the CDM. The "RD (Registered Dietician) Recommendation Form dated 8-6-2013 and provided by the CDM indicated "weekly wts (weights) x 4" for Resident #136.</p> <p>An interview with LPN #6 on 1-29-2014 at 9:53 a.m., indicated the LPN was not aware the Clinical Dietician recommended weekly weights on 8-6-2013 and that the Nutrition care plan dated 6-4-2013 and reviewed on 9/13 and 12/13 indicated "monitor weight weekly."</p> <p>2. The record review for Resident #224 began on 1-27-2014 at 2:07 p.m.</p> <p>Diagnoses included but were not limited to, a pelvis fracture, joint pain-pelvis, intermediate coronary syndrome, constipation, hypertension, esophageal reflux, depressive disorder, lumbago (lower back pain) and dysphagia (difficulty swallowing).</p> <p>A review of Resident #224 weights since</p>				

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	<p>admission on 12-17-2013 and provided by the facility were as follows:</p> <p>1-15-2014 106.4 lbs 1-8-2014 105.2 lbs 1-1-2014 104.3 lbs 12-25-2013 102.6 lbs 12-20-2013 110.6 lbs 12-19-2013 113 lbs 12-18-2013 113.6 lbs</p> <p>A review of Nutritional Progress Notes dated 1-3-2014 indicated the dietician recommended health shakes "120 ml (milliliters) po (by mouth) BID (twice a day) x 30 days" due to decreased oral intake and a "significant weight decrease."</p> <p>A review of the RD Recommendation Form provided by the CDM on 1-29-2014 at 10:59 a.m., indicated for Resident #224 a "health shake 120 ml po BID x 30 D (days)" was recommended.</p> <p>A review of the Social Service Assessment completed on 12-24-2013 indicated a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated resident was cognitively intact) and the 14 day assessment done on 12-31-2013 indicated a BIMS score of 15/15.</p> <p>An interview with Resident #224 on 1-28-2014 at 2:02 p.m., indicated she did</p>				

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	<p>not recall being provided health shakes.</p> <p>An interview with LPN #9 on 1-28-2014 at 2:10 p.m., indicated if a resident had a healthshake recommended by the dietician, it would be on the MAR (Medication Administration Record). LPN #9 indicated she was not sure how the dietician communicated with the staff on the recommendations.</p> <p>A review of Resident #224's physician order's and MAR indicated healthshakes were not listed.</p> <p>An interview with the DON (Director of Nursing) on 1-29-2014 at 9:20 a.m., indicated the Dietician did not notify the staff of the dietary recommendations for Resident #224 for the health shakes. The DON indicated the system used to notify staff of the Dietician recommendations was "broken".</p> <p>3. On 1/28/14 at 2 P.M., the clinical record of Resident #230 was reviewed. Diagnoses included, but were not limited to, the following: End Stage Renal Disease. The resident received dialysis three times a week.</p> <p>A "Nutrition Screening and Assessment"</p>			

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	<p>form dated 1/21/14 included, but was not limited to, the following: "...to have...Nepro 120 ml TID (three times a day) x 30 days...to help heal wound to buttock, Stage IV..."</p> <p>A plan of care, dated 1/23/14 indicated the following: Problem: Hemodialysis r/t end stage renal disease. Interventions included but were not limited to, the following: "Nepro supplement..."</p> <p>The January 2014 MAR (medication administration record) included, but was not limited to, the following: "Nepro - supplement 120 ml x 30 days." The Nepro had been documented as been given twice a day, at 8 A.M. and 5 P.M.</p> <p>On 1/28/14 at 2 40 P.M., the DON (Director of Nursing) was interviewed. She indicated the dietary recommendation is based from the Dietitian's recommendation.</p> <p>On 1/30/14 at 7:50 A.M., the FSM (food service manager) was interviewed. She indicated she was unsure why the resident had received Nepro BID when the dietary recommendation was for TID.</p> <p>A policy "Staff Registered Dietitian/Consultant Registered Dietitian" dated 2/13 and provided on</p>				

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F000323	<p>1-30-2014 at 2:00 p.m. by the Corporate Nurse, indicated the following: "...4. The Registered Dietitian prepares a list of recommendations at each visit and discusses these with the Food and Dining Services Manager and Director of Nursing. The Registered Dietitian prepares a report for the Executive Director, Food and Dining Services Manager and representative from nursing at each visit, outlining the registered Dietitian's activities, findings, new recommendations, and progress toward previous recommendations. The Registered Dietitian reviews the items identified on the report with this team in an exit interview. 5. The Executive Director and Food and Dining Services Manager acknowledge and act on the Registered Dietitian's Recommendations...."</p> <p>3.1-35(g)(2)</p> <p>483.25(h)</p>			

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SS=E	<p>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to ensure sharps containers, which contained potentially hazardous waste were secured for 4 of 7 medication carts reviewed.</p> <p>Findings include:</p> <p>On 1/28/14 at 11:37 A.M., the West hall medication cart was observed. An upright, sharps container was observed to be located on the right side of the medication cart. The height of the sharps container was approximately just below chest height for a 5 foot 2 inch person. The sharps container was resting in a plastic device which exposed the top portion of the sharps container but covered the front and both sides of the container approximately three fourths of the height of the container. The plastic device had a locking mechanism with a key hole on the front door portion of the device. When attempted, the front door of the plastic device easily opened, exposing the entire sharps container.</p> <p>At the time, LPN #11 was interviewed.</p>	F000323	<p>#1 On 1/28/2014 the sharps container on West hall both locks were fixed and locked. The cart on rehab was locked.#2 Maintenance on 1/28/2014 went to the medication carts and checked for any locks that were broken, not working or just not locked and he found that the locks on the sharps containers were working and locked on medication carts in the facility.#3 Staff to be inserviced on 2/25/2014 on the need to make sure sharp containers are attached and locked on all medication carts.#4 UM/designee will monitor the sharps container on each medication cart to make sure that the locks are working and are locked 5 times a week for 4 weeks, then 1 time weekly for 3 months, thereafter monthly. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months. #5 Systematic changes will be completed by 3/1/2014.</p>	03/01/2014
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	<p>She indicated she had the keys to lock the device which housed the sharps container on the medication cart.</p> <p>At the time, the other medication cart on the west unit was also found to have the sharps container locking device unlocked and the door easily opened as well as the sharps container on the only medication cart in the locked dementia unit. The two medication carts on the East unit were found to have both of their sharps containers locked. The Rehabilitation unit was found to have one sharps container locked on a medication cart and the other sharps container was unlocked. At the time these carts were observed, they were unattended.</p> <p>One of the sharps containers on the medication cart on the West unit and one on the Rehabilitation unit did not have the capability to even lock. When the door was opened, the interior portion of the locking mechanism had no interior device to lock the door with.</p> <p>At 11:57 A.M., the Administrator was made aware of the sharps containers which were not secured.</p> <p>On 1/28/14 at 1:28 P.M., the Administrator provided a current policy and procedure for "Handling and/or</p>			

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	<p>Disposing of used needles." The purpose of this policy was "To provide guidelines for the safe handling and disposal of used needles." This policy included, but was not limited to, the following: "When the sharps container is 3/4 filled, the container must be replaced according to the facility's policy. The full container must be stored until picked up by a licensed vendor for proper disposal." The Administrator was interviewed at the time and indicated the broken locks on the two devices housing the sharps containers had been fixed.</p> <p>On 1/28/14 at 2:35 P.M., the DON (Director of Nursing) was interviewed. She indicated the nurses take care of the sharps containers and remove them from the side of the cart when they are 3/4 full. She indicated the nurses then put the sharps containers in the biohazard dumpster.</p> <p>The DON indicated the nurses have a key for the locking mechanism housing the sharps containers. She indicated the sharps containers are secure as they can't be gotten into even though they are not locked to the medication carts. The DON indicated the facility policy does not indicate the sharps containers have to be secured to the medication cart.</p> <p>The Internet site of cdc.gov/niosh</p>			

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	<p>provided the following document: "Selecting, Evaluating, and Using Sharps Disposal Containers, U.S. Department for Health and Human Services; Public Health Service; Centers for Disease Control and Prevention; National Institute for Occupational Safety and Health; January 1998. Page 3 of this document included, but was not limited to, the following: "Special situations may require innovative sharps disposal container placement and security approaches. Examples of these special situations include pediatric and geriatric wards and mental health or correctional facilities. If necessary, in areas with high patient or visitor traffic, sharps disposal containers should be mounted in a lockable fixture.</p> <p>On 1/30/14 at 8 A.M., the Administrator provided the following list of current residents by unit who are considered to be confused and ambulatory and/or confused and can self propel in a wheelchair: West Unit: 3 residents confused and ambulatory; 2 residents were confused and self propel in wheelchair East Unit: 7 residents were confused and self propel in a wheelchair The locked Dementia Unit: 6 residents were confused and self propel in wheelchair and 10 residents are confused</p>			

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F000371 SS=E	<p>and ambulatory. The Rehabilitation unit had 1 resident who was confused and self propelled in a wheelchair.</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review the failed to ensure food was held and served at the appropriate temperature during 4 of 4 meal observations of meal service in 3 of 3 dining rooms potentially affecting 17 of 17 residents who ate their meals in the Bed and Breakfast dining room, 75 of 75 residents who received hall trays or ate their meals in the Main Dining Room, and 21 of 21 residents who ate their meals in the Rehabilitation dining room</p> <p>Findings include:</p>	F000371	<p>#1 Staff educated on the need to wash hands appropriately during meal service to residents. #2 Will observe dining room meal pass for proper handwashing. #3 Staff to be inserviced 2/25/2014 on proper handwashing when serving meals to residents. #4 DSD/designee will perform 5 random observations of proper handwashing technique during meal pass weekly times 1 month, then monthly times 3 months.. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months. #5 Systematic changes will be</p>	03/01/2014

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	<p>1. During an observation of the lunch meal on 1/23/14 in the Bed and Breakfast, the following was observed:</p> <ul style="list-style-type: none"> - At 11:05 a.m., a two tiered open service cart containing trays of pre-poured glasses of milk and pre-poured glasses of juice was in the dining room. The service cart was being moved from dining table to dining table by staff providing beverages to the residents seated at the dining tables. The pre-poured glasses of milk and the pre-poured glasses of juice were not on ice. - At 11:25 a.m., 9 glasses of milk and juice had already been served, leaving 7 glasses of milk and 5 glasses of juice not on ice on the service cart. - At 11:28 a.m., 1 glass of milk and 1 glass of juice were served to a resident. - At 11:30 a.m., 1 glass of milk and 1 glass of juice were served to a resident. - At 11:32 a.m., 1 glass of milk and 1 glass of juice were served to a resident. <p>At no time during the observation were the pre-poured glasses of milk or the pre-poured glasses of juice put on ice to</p>		<p>completed by 3/1/2014#1 Interviews completed and no complaints were voiced about temperature of food.#2 Resident interviews were conducted.#3 Foods being served in the Dining Room , Bed and Breakfast, and Rehab unit will be temped for meals before served. The temperatures will be entered in the temperature Log book for every meal. Staff to be inserviced on 2/28/2014.#4 Temperature Log Book will be monitored 3 times a week for a month, then weekly for 3 months, thereafter monthly times 3 months. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months. #5 Systematic changes to be complete by 3/1/2014.</p>				

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	<p>keep them at the proper temperature.</p> <p>2. During an observation of the lunch meal on 1/27/14 in the Bed and Breakfast, the following was observed:</p> <ul style="list-style-type: none"> - At 10:45 a.m., a three tiered open cart was in the kitchenette. An un-opened gallon of milk and a clear pitcher of apple juice were on the second tier of the cart. Neither the unopened gallon of milk or the clear pitcher of apple juice were on ice. - At 10:59 a.m., covered steam table pans of hot food were brought to the kitchenette by a Food Service employee and placed in the portable steam table units on the counter. LPN #2 began dishing food onto plates from the portable steam table units at 11:04 a.m. No temperatures of the hot food were taken prior to service, including the mechanically altered meat and the plate of pureed food. The un-opened gallon of milk and the clear pitcher of apple juice remained on the second tier of the cart not on ice. - At 11:10 a.m., Qualified Medication Aide (QMA) #3 was observed to open the refrigerator door in the kitchenette and obtained a partially filled gallon of milk, a partially filled clear plastic pitcher 			
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	<p>of cranberry juice, a partially filled clear plastic pitcher of apple juice, and a partially filled clear pitcher of orange juice. The beverages were placed on a service cart along with the unopened gallon of milk and the clear pitcher of apple juice on the three tiered cart already in the kitchenette at 10:45 a.m. The temperature of the milk and juice were not taken prior to service to the residents.</p> <p>- At 11:18 a.m., all residents in the Bed and Breakfast dining room had been served their food. The partially filled gallon of milk and the partially filled clear plastic pitchers of juices had been used during meal service. The unopened gallon of milk remained on the cart, not on ice.</p> <p>- At 11:28 a.m., QMA #3 opened the unopened gallon of milk and poured glasses of milk for several residents. The un-opened gallon of milk remained on the cart for 45 minutes before it was placed into the refrigerator and the partially opened gallon of milk and the clear pitchers of juice remained on the cart until empty. At no time were the beverages placed on ice to keep them at the proper temperature.</p> <p>A temperature log book could not be located in the kitchenette in the Bed and</p>			

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	<p>Breakfast.</p> <p>3. During an observation of the lunch meal on 1/28/13, the following was observed:</p> <ul style="list-style-type: none"> - At 10:55 a.m. in the main kitchen, 2 trays containing 9 individual bowls of tossed salad on each tray, 7 individual bowls of cottage cheese, 6 ounce cartons of chocolate milk, and 8 individual 4 ounce containers of yogurt were observed on the service counter ready for meal service. They were not on ice. - At 11:08 a.m. in the Bed and Breakfast, 2 trays containing pre-poured glasses of milk and pre-poured glasses of juice were removed from the refrigerator and placed on an open cart for meal service. Temperatures not taken to ensure the beverages were served at the proper temperature. - At 11:15 a.m. in the main kitchen, meal trays were being placed in the hall carts for the East Hall and for the West Hall. The individual bowls of tossed salad, the individual containers of chocolate milk, the individual bowls of cottage cheese, and the individual containers of yogurt were being placed on trays for the residents who ate their meals in their rooms. The items had not been on ice. 			
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	<p>- At 11:38 a.m. in the main dining room, five residents received individual bowls of tossed salad, one resident received an individual container of chocolate milk, and 1 resident received an individual container of cottage cheese.</p> <p>- At 11:42 a.m., 2 hall trays were taken from kitchen with individual bowls of tossed salad on their trays.</p> <p>At no time were the items placed on ice.</p> <p>4. During an observation of the lunch meal on 1/29/14, the following was observed:</p> <p>- At 12:01 p.m. in the Rehabilitation Unit, Dietary #4 was observed to push an open cart containing covered steam table pans and placed the steam table pans into the steam table. A covered plate containing slices of ham as the alternate meat was placed on the counter and not on a heat element to maintain the proper temperature.</p> <p>- At 12:03 p.m., Certified Nursing Assistant (CNA) #5 was observed to obtain an unopened 1/2 gallon of milk from the refrigerator in the kitchenette, placed it in a bin with ice, and started serving beverages to the residents seated</p>			

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	<p>at the dining room tables. She was not observed to take the temperature of the milk prior to service.</p> <p>- At 12:07 p.m., Dietary #4 was observed to remove 2 bowls of individual tossed salad from the refrigerator in the kitchenette and served them to two residents. The temperature of the tossed salad was not checked prior to service.</p> <p>- At 12:09 p.m., Dietary #4 was observed to start plating the hot food from the steam table for the residents in the dining room. The temperatures of the hot food were not taken prior to the start of service.</p> <p>A temperature log book could not be located in the kitchenette in the Rehabilitation Unit.</p> <p>The Certified Dietary Manager (CDM) was interviewed on 1/30/14 at 8:25 a.m. During the interview she indicated temperatures of food should be taken prior to service. She also indicated any un-used food was discarded.</p> <p>A current facility policy " Safe Food Temperatures", dated 2/09 and provided by the CDM on 1/30/14 at 9:25 a.m., indicated "...Food temperatures are maintained at acceptable levels</p>			

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	<p>during...holding, service, delivery...Hot foods will be held at 135 degrees F or higher during meals service (on the tray line)...Cold foods will be held at 41 degrees F or lower during meal service (on the tray line)...All tray line food temperatures are checked and recorded on the food temperature log...before each meal...Food temperatures are routinely monitored at point-of-service to the resident...."</p> <p>A current facility policy "Safe Food Handling", dated 2/09 and provided by the CDM on 1/30/14 at 9:25 a.m., indicated "...Potentially hazardous foods that are in a form to be consumed without further cooking...should be prepared from chilled ingredients and refrigerated to maintain temperatures of 41 degrees F or below until served...."</p> <p>3.1-21(a)(2)</p>			

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the pharmacist failed to notify the facility regarding the discrepancies in documentation for the PRN (as needed) narcotic medications signed out on the Controlled Substance Record and the lack of documentation on the MAR (Medication Administration Record) that</p>	F000425	#1 Medication carts on units containing PRN Narcotics were counted immediately on 1/23/2014. Corrections were made immediately during the survey. #2 A narcotic audit was completed on all residents receiving PRN narcotics on 1/31/2014.#3 Licensed nursing staff were inserviced immediatley on the proper policy	03/01/2014

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	<p>the narcotic was administered for 3 of 9 residents reviewed for documentation accuracy. (Resident #132, #136 and #224)</p> <p>Findings include:</p> <p>1. The record was reviewed for Resident #132 on 1-27-2014 at 10:01 a.m. Diagnoses included but were not limited to: Multiple Sclerosis, BPH (benign prostatic hyperplasia) without urinary obstruction, seizures, arthritis, TBI (traumatic brain injury, depression, constipation, chronic pain, hyperlipidemia and insomnia.</p> <p>The MDS (Minimum Data Set) quarterly assessment done on 11-1-2013 for Resident #132 indicated a BIMS (Brief Interview of Mental Status assessment that measures cognitive level) score of 8/15 (a score of 8 indicated moderately impaired).</p> <p>A review of the current physician's orders indicated Resident #132 had PRN (as needed) narcotic pain medication ordered as followed: "hydrocodone 10 mg (milligram)-acetaminophen 325 mg give 1 tablet by oral route every 6 hours as needed for breakthrough pain".</p> <p>A review of the Medication Regimen</p>		<p>and procedure for administration, counting, and documentation on 1/23/2014. Licensed nursing staff to be re-inserviced on 2/25/2014 on the proper administration, counting, and documentation of PRN narcotics based upon company's policy and procedure and state and federal regulations. #4 UM/ Designee will audit PRN Contolled Substance Sheets, shift to shift narcotic count sheets, and Administration records for completion on their perspective units, 5 times weekly for 4 weeks, then one time a week times 1 month, thereafter monthly times 3 months. Pharmacy Tech will continue to do random checks on a quarterly basis to continue to audit for compliance. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months. #5 Systematic changes will be completed 3/1/2/0124.</p>		

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	<p>Review for Resident #132 indicated the pharmacist reviewed Resident #132's medications on 1-22-2014 and did not document any discrepancies in narcotic counts.</p> <p>A review of the Medication Administration Record (MAR) and the Controlled Substances Record for Resident #132, from January 1st, 2014 and forward indicated the following discrepancies for Resident #132's hydrocodone:</p> <p>-On 1-5-2014, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances Record indicated the hydrocodone was signed out at 12:00 noon and 9:00 p.m.</p> <p>-On 1-12-2014, the MAR lacked documentation to indicate hydrocodone was administered at 8:00 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 10:00 a.m. and 8:00 p.m.</p> <p>-On 1-23-2014, the MAR lacked documentation to indicate hydrocodone was administered at 8:00 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out 8:00 p.m.</p>			

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	<p>-On 1-26-2014, the MAR lacked documentation to indicate hydrocodone was administered at 10:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out 10:00 a.m.</p> <p>A review of the current physician's recapitulation indicated Resident #132 had an order for clonazepam dated 11-27-2013 for 0.5 mg tablet "give 1 tablet (0.5 mg) by oral route once daily at bedtime.</p> <p>A review of Resident #132's clonazepam 1 mg Controlled Substance Record indicated the following:</p> <p>-On 12-23-2013 at 8:00 p.m., 0.5 mg was given and the count prior to the dose was written "24" and after the 0.5 mg tablet was given, the count was written "23."</p> <p>-On 12-26-2013 at 8:00 p.m., 0.5 mg was given and the count prior to the dose was written "22.0" and after the 0.5 mg tablet was given, the count was written "21.0."</p> <p>-On 1-2-2014 at 8:00 p.m., 0.5 mg was given and the count prior to the dose was written "17.5" and after the 0.5 mg tablet was given, the count was written "16.5."</p> <p>-On 1-3-2014 at 8:00 p.m., 0.5 mg was</p>			

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	<p>given and the count prior to the dose was written "16.5" and after the 0.5 mg tablet was given, the count was written "15.5."</p> <p>-On 1-23-2014 at 8 p.m., 0.5 mg was given and the count prior to the dose was written "6" and after the 0.5 mg tablet was given, the count was written "5."</p> <p>An interview with LPN #1 on 1-30-2014 at 9:40 a.m., indicated she was not aware some documentation was not entered on the MAR for the administration of the prn controlled substance medications signed out by the nurse. LPN #1 indicated there was not a double check system in place to reconcile the signed out controlled substances to be sure they were also documented on the MAR. An LPN #1 indicated she was not aware that Resident #132's Controlled Substance Record entries for clonazepam 1 mg dated 12-23-13, 12-26-13, 1-2-14, 1-3-14 and 1-23-14 indicated 1 tablet was signed out when the order was for 1/2 tablet (0.5 mg).</p> <p>An interview with the DON on 1-30-2013 at 2:20 p.m., indicated the clonazepam for Resident #132 came from the VA (Veteran's Administration) in 1 mg un-scored tablets and staff had to cut the tablet in half. The DON indicated the documentation on the Controlled</p>			

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	<p>Substance Record for the clonazepam on 12-23 and 26, 2013 and on 1-2,3 and 23, 2014 was a documentation error.</p> <p>2. The record review for Resident #136 began on 1-27-2014 at 11:27 a.m. The diagnoses included but were not limited to, COPD (chronic obstructive pulmonary disease), pain in limb, insomnia, esophageal reflux, depression and chronic pain.</p> <p>The MDS (Minimum Data Set) quarterly assessment done on 12-10-2013 for Resident #136 indicated a BIMS score of 15/15 which indicated the resident was cognitively intact.</p> <p>A review of the current physician's orders indicated Resident #136 had PRN narcotic pain medication ordered as followed: "oxycodone-acetaminophen 10 mg-325 mg tablet-give 1 tablet orally every 4 hours as needed for pain - max of 4 tabs per day."</p> <p>A review of the Medication Regimen Review for Resident #136 indicated the pharmacist reviewed Resident #136's medications on 1-22-2014 and did not document any discrepancies in narcotic counts.</p> <p>A review of the Medication</p>			

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	<p>Administration Record and the Controlled Substances Record for Resident #136, from January 1st, 2014 and forward indicated the following discrepancies for Resident #136's oxycodone:</p> <p>--On 1-2-2014, the MAR lacked documentation to indicate oxycodone was administered 7:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 3:40 a.m. and 11:30 a.m. and 7:00 p.m.</p> <p>--On 1-3-2014, the MAR lacked documentation to indicate oxycodone was administered 9:25 a.m., 4:00 p.m. and 10:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:00 a.m., 9:25 a.m., 4:00 p.m. and 10:00 p.m.</p> <p>-On 1-4-2014, the MAR lacked documentation to indicate oxycodone was administered 3:00 a.m., 12:25 p.m., 7:00 p.m. and 11:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 3:00 a.m., 12:25 p.m., 7:00 p.m. and 11:30 p.m.</p> <p>-On 1-5-2014, the MAR lacked documentation to indicate oxycodone was administered at 1:30 p.m. and 7:00</p>			

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	<p>p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 8:00 a.m., 1:30 p.m. and 7:00 p.m.</p> <p>-On 1-6-2014, the MAR lacked documentation to indicate oxycodone was administered at 11:30 a.m. and the Controlled Substances Record indicated the oxycodone was signed out at 4:00 a.m., 11:30 a.m. and 7:30 p.m.</p> <p>-On 1-7-2014, the MAR lacked documentation to indicate oxycodone was administered at 8:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 3:00 a.m., 12:00 p.m. and 8:00 p.m.</p> <p>-On 1-9-2014, the MAR lacked documentation to indicate oxycodone was administered at 6:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 3:45 a.m., 11:30 a.m. and 6:30 p.m.</p> <p>-On 1-10-2014, the MAR lacked documentation to indicate oxycodone was administered at 11:40 a.m. and the Controlled Substances Record indicated the oxycodone was signed out at 11:40 a.m. and 7:00 p.m.</p> <p>-On 1-12-2014, the MAR lacked</p>			

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	<p>documentation to indicate oxycodone was administered at 3:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 11:30 a.m., 3:30 p.m. and 11:00 p.m.</p> <p>-On 1-14-2014, the MAR lacked documentation to indicate oxycodone was administered at 4:15 p.m. and 10:05 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:45 a.m., 11:30 a.m., 4:15 p.m. and 10:05 p.m.</p> <p>-On 1-15-2014, the MAR lacked documentation to indicate oxycodone was administered at 6:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 11:35 a.m., 6:30 p.m. and 11:00 p.m.</p> <p>-On 1-16-2014, the MAR lacked documentation to indicate oxycodone was administered at 6:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 11:30 a.m. and 6:30 p.m.</p> <p>-On 1-17-2014, the MAR lacked documentation to indicate oxycodone was administered at 6:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:35 a.m., 11:30 a.m. and 6:00 p.m.</p>			

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	<p>-On 1-18-2014, the MAR lacked documentation to indicate oxycodone was administered at 2:00 a.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:00 a.m., 12:00 p.m. and 6:41 p.m.</p> <p>-On 1-20-2014, the MAR lacked documentation to indicate oxycodone was administered at 7:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 4:00 a.m., 12:00 p.m. and 7:00 p.m.</p> <p>-On 1-21-2014, the MAR lacked documentation to indicate oxycodone was administered at 8:30 p.m. and 9:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 1:30 a.m., 10:15 a.m., 8:30 p.m. and 9:30 p.m.</p> <p>-On 1-23-2014, the MAR lacked documentation to indicate oxycodone was administered at 1:00 p.m. and 9:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:00 a.m., 1:00 p.m. and 9:00 p.m.</p> <p>-On 1-26-2014, the MAR lacked documentation to indicate oxycodone was administered at 7:30 p.m. and the</p>			

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	<p>Controlled Substances Record indicated the oxycodone was signed out at 11:10 a.m. and 7:30 p.m.</p> <p>-On 1-27-2014, the MAR lacked documentation to indicate oxycodone was administered at 10:00 p.m., and the Controlled Substances Record indicated the oxycodone was signed out at 6:30 a.m., 11:30 a.m. and 10:00 p.m.</p> <p>-On 1-28-2014, the MAR lacked documentation to indicate oxycodone was administered at 2:30 a.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:30 a.m., 11:30 a.m. and 6:30 p.m.</p> <p>An interview with Resident #136 on 1-29-2014 a 1:56 p.m., indicated she received her oxycodone medication from the nurse when she asked for it.</p> <p>3. The record review for Resident #224 began on 1-27-2014 at 2:07 p.m. Diagnoses included but were not limited to, a pelvis fracture, joint pain-pelvis, intermediate coronary syndrome, constipation, hypertension, esophageal reflux, depressive disorder, lumbago (lower back pain) and dysphagia (difficulty swallowing).</p> <p>A review of the Social Service</p>						

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	<p>Assessment completed on 12-24-2013 indicated a BIMS score of 15/15 (indicated resident was cognitively intact) and the 14 day assessment done on 12-31-2013 indicated a BIMS score of 15/15.</p> <p>A review of the current physician's orders indicated Resident #224 had PRN narcotic pain medication ordered as followed: "hydrocodone 5 mg-acetaminophen 325 mg tablet give 1 tablet by oral route every 4 hours as needed give 1 tab for mild to moderate pain...give 2 tablets every 4 hours prn for moderate to severe pain...."</p> <p>A review of the Medication Regimen Review for Resident #224 indicated the pharmacist reviewed Resident #224's medications on 1-29-2014 and did not document any discrepancies in narcotic counts.</p> <p>A review of the Medication Administration Record and the Controlled Substances Record for Resident #224, from January 1st, 2014 and forward indicated the following discrepancies for Resident #224's hydrocodone:</p> <p>-On 1-2-2014, the MAR lacked documentation to indicate hydrocodone</p>			

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	<p>was administered 10:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 3:00 a.m. and 9:00 a.m. and 10:30 p.m.</p> <p>-On 1-3-2014, the MAR lacked documentation to indicate hydrocodone was administered at 6:30 a.m. and 10:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 6:30 a.m., 12:50 p.m. and 10:30 p.m.</p> <p>-On 1-4-2014, the MAR lacked documentation to indicate hydrocodone was administered at 6:30 a.m., 6 p.m. and 12:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 6:30 a.m., 10:30 a.m., 6:00 p.m. and 12:00 a.m.</p> <p>-On 1-5-2014, the MAR lacked documentation to indicate hydrocodone was administered at 12:30 p.m., 4:30 p.m. and 8:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 8:30 a.m., 12:30 p.m., 4:30 p.m. and 8:30 p.m.</p> <p>-On 1-6-2014, the MAR lacked documentation to indicate hydrocodone was administered at 12:30 a.m. and 7:00 p.m. and the Controlled Substances Record indicated the hydrocodone was</p>			

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	<p>signed out at 12:30 a.m., 8:00 a.m., 1:00 p.m. and 7:00 p.m.</p> <p>-On 1-7-2014, the MAR lacked documentation to indicate hydrocodone was administered at 12:00 a.m., 10:50 a.m., 2:50 p.m. and 7:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 12:00 a.m., 10:50 a.m., 2:50 p.m. and 7:30 p.m.</p> <p>-On 1-8-2014, the MAR lacked documentation to indicate hydrocodone was administered at 8:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 4:30 a.m., 12:10 p.m. and 8:30 p.m.</p> <p>-On 1-9-2014, the MAR lacked documentation to indicate hydrocodone was administered at 1:30 p.m. and 8:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 2:45 a.m., 7:30 a.m., 1:30 p.m. and 8:30 p.m.</p> <p>-On 1-10-2014, the MAR lacked documentation to indicate hydrocodone was administered at 2:30 a.m. and 5:00 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 2:30 a.m., 9:40 a.m. and 5:00 p.m.</p>			

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	<p>-On 1-11-2014, the MAR lacked documentation to indicate hydrocodone was administered at 7:00 a.m. and 4:00 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 7:00 a.m., 4:00 p.m. and 8:30 p.m.</p> <p>-On 1-12-2014, the MAR lacked documentation to indicate hydrocodone was administered at 2:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 2:00 a.m., 3:20 p.m. and 10:30 p.m.</p> <p>-On 1-13-2014, the MAR lacked documentation to indicate hydrocodone was administered at 8:00 a.m., 1:00 p.m. and 9:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 8:00 a.m., 1:00 p.m. and 9:30 p.m.</p> <p>-On 1-14-2014, the MAR lacked documentation to indicate hydrocodone was administered at 1:30 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 1:30 a.m., 5:30 a.m., 9:30 a.m. and 4:30 p.m.</p> <p>-On 1-15-2014, the MAR lacked documentation to indicate hydrocodone was administered at 9:00 p.m. and the Controlled Substances Record indicated</p>			

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	<p>the hydrocodone was signed out at 1:30 a.m., 9:34 a.m. and 9:00 p.m.</p> <p>-On 1-16-2014, the MAR lacked documentation to indicate hydrocodone was administered at 12:30 p.m. and an unidentified time and the Controlled Substances Record indicated the hydrocodone was signed out at 8:00 a.m., 12:30 p.m. and an unidentified time.</p> <p>-On 1-17-2014, the MAR lacked documentation to indicate hydrocodone was administered at 10:30 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 4:00 a.m., 10:30 a.m. and 8:20 p.m.</p> <p>-On 1-18-2014, the MAR lacked documentation to indicate hydrocodone was administered at 2:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 2:00 a.m., 11:00 a.m. and 8:00 p.m.</p> <p>-On 1-21-2014, the MAR lacked documentation to indicate hydrocodone was administered at 4:00 a.m., 3:30 p.m. and 10:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 4:00 a.m., 3:30 p.m. and 10:30 p.m.</p> <p>-On 1-22-2014, the MAR lacked</p>			

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	<p>documentation to indicate hydrocodone was administered at 9:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 9:00 a.m. and 4:00 p.m.</p> <p>-On 1-24-2014, the MAR lacked documentation to indicate hydrocodone was administered at 1:45 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 7:45 a.m., 1:45 p.m. and 8:30 p.m.</p> <p>-On 1-25-2014, the MAR lacked documentation to indicate hydrocodone was administered at 3:45 a.m. and 10:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 3:45 a.m., 10:00 a.m. and 6:36 p.m.</p> <p>-On 1-27-2014, the MAR lacked documentation to indicate hydrocodone was administered at 2:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 2:00 a.m., 7:15 a.m. and 7:00 p.m.</p> <p>An interview with LPN #1 on 1-29-2014 at 2:00 p.m., indicated when a resident requested a prn narcotic pain medication, the nurse was to document the medication in the MAR and on the Controlled Substances Record.</p>			

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	<p>An interview with LPN #1 on 1-30-2014 at 9:40 a.m., indicated she was not aware some documentation was not entered on the MAR for the administration of the prn controlled substance medications signed out by the nurse. LPN #1 indicated there was not a double check system in place to reconcile the signed out controlled substances to be sure they were also documented on the MAR. An LPN #1 indicated she was not aware that Resident #132's Controlled Substance Record entries for clonazepam 1 mg dated 12-23-13, 12-26-13, 1-2-14, 1-3-14 and 1-23-14 indicated 1 tablet was signed out when the order was for 1/2 tablet (0.5 mg).</p> <p>An interview with LPN #6 on 1-30-2014 at 10:10 a.m., indicated when a resident requested a narcotic pain med, the medication was signed out on the Controlled Substance Record, administered to the resident and documented in the MAR.</p> <p>An interview with LPN #8 on 1-30-2014 at 10:30 a.m., indicated when a resident requested a narcotic pain med, she would assess their pain, review the orders, obtain the narcotic pain medication and sign out the narcotic on the resident's Controlled Substance Record and record</p>			

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	<p>the administration of the narcotic in the MAR.</p> <p>An interview with RN #7, the Rehabilitation Manager on 1-30-2014 at 11:25 a.m., indicated she was made aware on 1-29-2014 that there were discrepancies between the documentation on the Controlled Substance Record and the MAR.</p> <p>An interview with Resident #224 on 1-30-2014 at 11:53 a.m., indicated she received the hydrocodone pain medication when she asked the nurse.</p> <p>An interview with the Corporate Nurse on 1-30-2014 at 12:32 p.m., indicated the pharmacy tech reviewed the medication carts quarterly including the narcotics.</p> <p>A policy "Storage and Expiration Dating of Medication, Biologicals, Syringes and Needles" dated 5-10-2010 and provided by the DON on 1-30-2014 indicated "...facility should request that Pharmacy perform a routine nursing unit inspection for each nursing station in Facility to assist Facility in complying with its obligations pursuant to Applicable Law relating to the proper storage, labeling, security and accountability of medications and biologicals...."</p>			

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F000431	<p>On 1-30-2014 at 2:25 p.m., a checklist for the Medication Cart review was provided by the Corporate Nurse on and indicated "...controlled substance inventory is reconciled per facility policy...."</p> <p>3.1-25(e)(2) 3.1-25(e)(3)</p> <p>483.60(b), (d), (e)</p>			

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SS=E	<p>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, interview and record review, the facility failed to ensure opened insulin vials and eye drop vials were labeled with dates they were opened and/or</p>	F000431	#1 On 1/30/2014 all medication carts were audited for any medications not dated or OTC medications labeled with resident's name. #2 On 1/30/2014 medication carts were	03/01/2014

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	<p>over the counter (OTC) medication bottles were labeled with resident's names and/or physician name in 4 of 6 medication carts.</p> <p>Findings include:</p> <p>1. On 1/30/14 at 9:40 A.M., the medication cart on the dementia unit was observed. LPN #2 indicated the following opened vials of medications lacked documentation as to when they had been opened: Novolog insulin, Lantus Insulin and a vial of Vitamin B12. At this time, LPN #2 was interviewed. He indicated the vial of Novolog insulin had been removed from the EDK (Emergency Drug Kit) several weeks ago.</p> <p>The following OTC medications were located in a drawer of the medication cart and did not have any resident name or physician name on them: D3, 1000 IU (international units); Zinc 30 mg and Bio B Complex.</p> <p>At the time, LPN #2 was interviewed. He was aware of who the unlabeled medications belonged to based on the location of the medications in the med cart drawer. He indicated he knew they</p>		<p>audited for any medications not dated or OTC medications labeled with resident's name. #3 Staff will be inserviced on 2/25/2014 on the proper storage and labeling of medications.#4 UM/ designee will audit carts to ensure insulins, eyedrops and OTC medications are labeled and dated when opened, Carts will be audited 5 times a week for 1 month , then 2 times a week for a month and weekly thereafter. Results of audits will be forwarded to QA to review tracking and trending monthly for a minimum of 6 months. #5 Systematic changes will be completed by 3/1/2014.</p>	

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	<p>belonged to this resident because of the drawer they were placed in on the medication cart.</p> <p>In the bottom drawer of the medication cart, there were 5 opened bottles of Milk of Magnesia, which were opened, but not dated as to when they were opened.</p> <p>2. On 1/30/14 at 10 A.M., one of the medication carts on the West hall was observed with LPN #13. Observed on the cart was a otc bottle of daily multivitamins which had no physician name and/or resident name. LPN #13 was interviewed at the time and indicated she knew who the medication belonged to based on where it was located in the medication cart.</p> <p>On 1/30/14 at 11:45 A.M., the DON (Director of Nursing) was interviewed. She indicated over the counter (OTC) medications should have the resident's name on them.</p> <p>3. During an observation of the East hall medication cart with LPN</p>				

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	<p>#6 on 1-30-2013 at 10:09 a.m, the following opened vials were not labeled with an open date: -a vial of Levemir insulin -a vial of Latanoprost ophthalmic solution -2 vials of artificial tears</p> <p>An interview with LPN #6 on 1-30-2014 at 10:10 a.m., indicated the opened vials of insulin and eye drops should have an open date recorded on the containers.</p> <p>4. During an observation of the Rehabilitation medication cart #2 with RN #10 on 1-30-2014 at 10:25 a.m., the following opened vials were not labeled with an open date: -a vial of Novolog insulin -a vial of Lantus insulin</p> <p>An interview with RN #10 on 1-30-2014 at 10:26 a.m., indicated the insulins should have an open date on them.</p> <p>On 1/30/14 at 11:30 A.M. a current copy of the facility policy and procedure for "Storage and Expiration Dating of Medications..." was provided by the DON. This policy was dated 5/10/10 and included, but was not limited to,</p>				

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	<p>the following: "...once any medication...is opened, facility...staff should record the date opened on the medication container when the medication has a shortened expiration date once opened..."</p> <p>3.1-25(m)</p>			

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F000514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to ensure accurate reconciliation of the MAR (Medication Administration Record) and the Controlled Substance Record for 6 of</p>	F000514	#1 Medication carts on units containing PRN Narcotics were counted immediately on 1/23/2014. In addition Corrections were made during the survey.#2 A narcotic audit was	03/01/2014

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	<p>9 residents who were administered scheduled and PRN (as needed) narcotic pain medications, (Residents #132, #136, #224, #230, #234, #74) and the facility failed to ensure accurate documentation for the disposition of a 1/2 tab of clonazepam on the Controlled Substance Record for 1 of 9 residents reviewed for narcotic medications. (Resident #132).</p> <p>Findings include:</p> <p>1. The record was reviewed for Resident #132 on 1-27-2014 at 10:01 a.m. Diagnoses included but were not limited to: Multiple Sclerosis, BPH (benign prostatic hyperplasia) without urinary obstruction, seizures, arthritis, TBI (traumatic brain injury), depression, constipation, chronic pain, hyperlipidemia and insomnia.</p> <p>The MDS (Minimum Data Set) quarterly assessment done on 11-1-2013 for Resident #132 indicated a BIMS (Brief Interview of Mental Status assessment that measures cognitive level) score of 8/15 (a score of 8 indicated moderately impaired).</p> <p>A review of the current physician's orders indicated Resident #132 had PRN (as needed) narcotic pain medication ordered</p>		<p>completed on all residents receiving PRN narcotics on 1/31/2014.#3 Licensed nursing staff were inserviced immediatley on the proper policy and procedure for administration, counting, and documentation on 1/23/2014. Licensed nursing staff to be re-inserviced on 2/25/2014 on the proper administration, counting, and documentation of PRN narcotics based upon company's policy and procedure and state and federal regulations. #4 UM/ Designee will audit PRN Contolled Substance Sheets, shift to shift narcotic count sheets, and Administration records for completion on their perspective units, 5 times weekly for 4 weeks, then one time a week times 1 month, thereafter monthly times 3 months. Pharmacy Tech will continue to do random checks on a quarterly basis to continue to audit for compliance. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months. #5 Systematic changes will be completed 3/1/2/0124.</p>				

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	<p>as followed: "hydrocodone 10 mg (milligram)-acetaminophen 325 mg give 1 tablet by oral route every 6 hours as needed for breakthrough pain".</p> <p>A review of the Medication Regimen Review for Resident #132 indicated the pharmacist reviewed Resident #132's medications on 1-22-2014.</p> <p>A review of the Medication Administration Record (MAR) and the Controlled Substances Record for Resident #132, from January 1st, 2014 and forward indicated the following discrepancies for Resident #132's hydrocodone:</p> <p>-On 1-5-2014, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances Record indicated the hydrocodone was signed out at 12:00 noon and 9:00 p.m.</p> <p>-On 1-12-2014, the MAR lacked documentation to indicate hydrocodone was administered at 8:00 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 10:00 a.m. and 8:00 p.m.</p> <p>-On 1-23-2014, the MAR lacked documentation to indicate hydrocodone</p>			

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	<p>was administered at 8:00 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out 8:00 p.m.</p> <p>-On 1-26-2014, the MAR lacked documentation to indicate hydrocodone was administered at 10:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out 10:00 a.m.</p> <p>A review of the current physician's recapitulation indicated Resident #132 had an order for clonazepam dated 11-27-2013 for 0.5 mg tablet "give 1 tablet (0.5 mg) by oral route once daily at bedtime.</p> <p>A review of Resident #132's clonazepam 1 mg Controlled Substance Record indicated the following:</p> <p>-On 12-23-2013 at 8:00 p.m., 0.5 mg was given and the count prior to the dose was written "24" and after the 0.5 mg tablet was given, the count was written "23."</p> <p>-On 12-26-2013 at 8:00 p.m., 0.5 mg was given and the count prior to the dose was written "22.0" and after the 0.5 mg tablet was given, the count was written "21.0."</p> <p>-On 1-2-2014 at 8:00 p.m., 0.5 mg was given and the count prior to the dose was</p>				

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	<p>written "17.5" and after the 0.5 mg tablet was given, the count was written "16.5."</p> <p>-On 1-3-2014 at 8:00 p.m., 0.5 mg was given and the count prior to the dose was written "16.5" and after the 0.5 mg tablet was given, the count was written "15.5."</p> <p>-On 1-23-2014 at 8 p.m., 0.5 mg was given and the count prior to the dose was written "6" and after the 0.5 mg tablet was given, the count was written "5."</p> <p>An interview with LPN #1 on 1-30-2014 at 9:40 a.m., indicated she was not aware some documentation was not entered on the MAR for the administration of the prn controlled substance medications signed out by the nurse. LPN #1 indicated there was not a double check system in place to reconcile the signed out controlled substances to be sure they were also documented on the MAR. An LPN #1 indicated she was not aware that Resident #132's Controlled Substance Record entries for clonazepam 1 mg dated 12-23-13, 12-26-13, 1-2-14, 1-3-14 and 1-23-14 indicated 1 tablet was signed out when the order was for 1/2 tablet (0.5 mg).</p> <p>An interview with the DON on 1-30-2013 at 2:20 p.m., indicated the clonazepam for Resident #132 came from</p>			

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	<p>the VA (Veteran's Administration) in 1 mg un-scored tablets and staff had to cut the tablet in half. The DON indicated the documentation on the Controlled Substance Record for the clonazepam on 12-23 and 26, 2013 and on 1-2,3 and 23, 2014 was a documentation error.</p> <p>2. The record review for Resident #136 began on 1-27-2014 at 11:27 a.m. The diagnoses included but were not limited to, COPD (chronic obstructive pulmonary disease), pain in limb, insomnia, esophageal reflux, depression and chronic pain.</p> <p>The MDS (Minimum Data Set) quarterly assessment done on 12-10-2013 for Resident #136 indicated a BIMS score of 15/15 which indicated the resident was cognitively intact.</p> <p>A review of the current physician's orders indicated Resident #136 had PRN narcotic pain medication ordered as followed: "oxycodone-acetaminophen 10 mg-325 mg tablet-give 1 tablet orally every 4 hours as needed for pain - max of 4 tabs per day."</p> <p>A review of the Medication Administration Record and the Controlled Substances Record for Resident #136, from January 1st, 2014</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and forward indicated the following discrepancies for Resident #136's oxycodone:</p> <p>--On 1-2-2014, the MAR lacked documentation to indicate oxycodone was administered 7:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 3:40 a.m. and 11:30 a.m. and 7:00 p.m.</p> <p>--On 1-3-2014, the MAR lacked documentation to indicate oxycodone was administered 9:25 a.m., 4:00 p.m. and 10:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:00 a.m., 9:25 a.m., 4:00 p.m. and 10:00 p.m.</p> <p>-On 1-4-2014, the MAR lacked documentation to indicate oxycodone was administered 3:00 a.m., 12:25 p.m., 7:00 p.m. and 11:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 3:00 a.m., 12:25 p.m., 7:00 p.m. and 11:30 p.m.</p> <p>-On 1-5-2014, the MAR lacked documentation to indicate oxycodone was administered at 1:30 p.m. and 7:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 8:00 a.m., 1:30 p.m. and</p>			

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	<p>7:00 p.m.</p> <p>-On 1-6-2014, the MAR lacked documentation to indicate oxycodone was administered at 11:30 a.m. and the Controlled Substances Record indicated the oxycodone was signed out at 4:00 a.m., 11:30 a.m. and 7:30 p.m.</p> <p>-On 1-7-2014, the MAR lacked documentation to indicate oxycodone was administered at 8:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 3:00 a.m., 12:00 p.m. and 8:00 p.m.</p> <p>-On 1-9-2014, the MAR lacked documentation to indicate oxycodone was administered at 6:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 3:45 a.m., 11:30 a.m. and 6:30 p.m.</p> <p>-On 1-10-2014, the MAR lacked documentation to indicate oxycodone was administered at 11:40 a.m. and the Controlled Substances Record indicated the oxycodone was signed out at 11:40 a.m. and 7:00 p.m.</p> <p>-On 1-12-2014, the MAR lacked documentation to indicate oxycodone was administered at 3:30 p.m. and the Controlled Substances Record indicated</p>			

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	<p>the oxycodone was signed out at 11:30 a.m., 3:30 p.m. and 11:00 p.m.</p> <p>-On 1-14-2014, the MAR lacked documentation to indicate oxycodone was administered at 4:15 p.m. and 10:05 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:45 a.m., 11:30 a.m., 4:15 p.m. and 10:05 p.m.</p> <p>-On 1-15-2014, the MAR lacked documentation to indicate oxycodone was administered at 6:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 11:35 a.m., 6:30 p.m. and 11:00 p.m.</p> <p>-On 1-16-2014, the MAR lacked documentation to indicate oxycodone was administered at 6:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 11:30 a.m. and 6:30 p.m.</p> <p>-On 1-17-2014, the MAR lacked documentation to indicate oxycodone was administered at 6:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:35 a.m., 11:30 a.m. and 6:00 p.m.</p> <p>-On 1-18-2014, the MAR lacked documentation to indicate oxycodone</p>			

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	<p>was administered at 2:00 a.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:00 a.m., 12:00 p.m. and 6:41 p.m.</p> <p>-On 1-20-2014, the MAR lacked documentation to indicate oxycodone was administered at 7:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 4:00 a.m., 12:00 p.m. and 7:00 p.m.</p> <p>-On 1-21-2014, the MAR lacked documentation to indicate oxycodone was administered at 8:30 p.m. and 9:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 1:30 a.m., 10:15 a.m., 8:30 p.m. and 9:30 p.m.</p> <p>-On 1-23-2014, the MAR lacked documentation to indicate oxycodone was administered at 1:00 p.m. and 9:00 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:00 a.m., 1:00 p.m. and 9:00 p.m.</p> <p>-On 1-26-2014, the MAR lacked documentation to indicate oxycodone was administered at 7:30 p.m. and the Controlled Substances Record indicated the oxycodone was signed out at 11:10 a.m. and 7:30 p.m.</p>			

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	<p>-On 1-27-2014, the MAR lacked documentation to indicate oxycodone was administered at 10:00 p.m., and the Controlled Substances Record indicated the oxycodone was signed out at 6:30 a.m., 11:30 a.m. and 10:00 p.m.</p> <p>-On 1-28-2014, the MAR lacked documentation to indicate oxycodone was administered at 2:30 a.m. and the Controlled Substances Record indicated the oxycodone was signed out at 2:30 a.m., 11:30 a.m. and 6:30 p.m.</p> <p>3. The record review for Resident #224 began on 1-27-2014 at 2:07 p.m. Diagnoses included but were not limited to, a pelvis fracture, joint pain-pelvis, intermediate coronary syndrome, constipation, hypertension, esophageal reflux, depressive disorder, lumbago (lower back pain) and dysphagia (difficulty swallowing).</p> <p>A review of the current physician's orders indicated Resident #224 had PRN narcotic pain medication ordered as followed: "hydrocodone 5 mg-acetaminophen 325 mg tablet give 1 tablet by oral route every 4 hours as needed give 1 tab for mild to moderate pain...give 2 tablets every 4 hours prn for moderate to severe pain...."</p>			

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	<p>A review of the Medication Administration Record and the Controlled Substances Record for Resident #224, from January 1st, 2014 and forward indicated the following discrepancies for Resident #224's hydrocodone:</p> <p>-On 1-2-2014, the MAR lacked documentation to indicate hydrocodone was administered 10:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 3:00 a.m. and 9:00 a.m. and 10:30 p.m.</p> <p>-On 1-3-2014, the MAR lacked documentation to indicate hydrocodone was administered at 6:30 a.m. and 10:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 6:30 a.m., 12:50 p.m. and 10:30 p.m.</p> <p>-On 1-4-2014, the MAR lacked documentation to indicate hydrocodone was administered at 6:30 a.m., 6 p.m. and 12:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 6:30 a.m., 10:30 a.m., 6:00 p.m. and 12:00 a.m.</p> <p>-On 1-5-2014, the MAR lacked documentation to indicate hydrocodone</p>			

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	<p>was administered at 12:30 p.m., 4:30 p.m. and 8:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 8:30 a.m., 12:30 p.m., 4:30 p.m. and 8:30 p.m.</p> <p>-On 1-6-2014, the MAR lacked documentation to indicate hydrocodone was administered at 12:30 a.m. and 7:00 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 12:30 a.m., 8:00 a.m., 1:00 p.m. and 7:00 p.m.</p> <p>-On 1-7-2014, the MAR lacked documentation to indicate hydrocodone was administered at 12:00 a.m., 10:50 a.m., 2:50 p.m. and 7:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 12:00 a.m., 10:50 a.m., 2:50 p.m. and 7:30 p.m.</p> <p>-On 1-8-2014, the MAR lacked documentation to indicate hydrocodone was administered at 8:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 4:30 a.m., 12:10 p.m. and 8:30 p.m.</p> <p>-On 1-9-2014, the MAR lacked documentation to indicate hydrocodone was administered at 1:30 p.m. and 8:30 p.m. and the Controlled Substances Record indicated the hydrocodone was</p>			

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	<p>signed out at 2:45 a.m., 7:30 a.m., 1:30 p.m. and 8:30 p.m.</p> <p>-On 1-10-2014, the MAR lacked documentation to indicate hydrocodone was administered at 2:30 a.m. and 5:00 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 2:30 a.m., 9:40 a.m. and 5:00 p.m.</p> <p>-On 1-11-2014, the MAR lacked documentation to indicate hydrocodone was administered at 7:00 a.m. and 4:00 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 7:00 a.m., 4:00 p.m. and 8:30 p.m.</p> <p>-On 1-12-2014, the MAR lacked documentation to indicate hydrocodone was administered at 2:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 2:00 a.m., 3:20 p.m. and 10:30 p.m.</p> <p>-On 1-13-2014, the MAR lacked documentation to indicate hydrocodone was administered at 8:00 a.m., 1:00 p.m. and 9:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 8:00 a.m., 1:00 p.m. and 9:30 p.m.</p>			

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	<p>-On 1-14-2014, the MAR lacked documentation to indicate hydrocodone was administered at 1:30 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 1:30 a.m., 5:30 a.m., 9:30 a.m. and 4:30 p.m.</p> <p>-On 1-15-2014, the MAR lacked documentation to indicate hydrocodone was administered at 9:00 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 1:30 a.m., 9:34 a.m. and 9:00 p.m.</p> <p>-On 1-16-2014, the MAR lacked documentation to indicate hydrocodone was administered at 12:30 p.m. and an unidentified time and the Controlled Substances Record indicated the hydrocodone was signed out at 8:00 a.m., 12:30 p.m. and an unidentified time.</p> <p>-On 1-17-2014, the MAR lacked documentation to indicate hydrocodone was administered at 10:30 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 4:00 a.m., 10:30 a.m. and 8:20 p.m.</p> <p>-On 1-18-2014, the MAR lacked documentation to indicate hydrocodone was administered at 2:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 2:00</p>			

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	<p>a.m., 11:00 a.m. and 8:00 p.m.</p> <p>-On 1-21-2014, the MAR lacked documentation to indicate hydrocodone was administered at 4:00 a.m., 3:30 p.m. and 10:30 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 4:00 a.m., 3:30 p.m. and 10:30 p.m.</p> <p>-On 1-22-2014, the MAR lacked documentation to indicate hydrocodone was administered at 9:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 9:00 a.m. and 4:00 p.m.</p> <p>-On 1-24-2014, the MAR lacked documentation to indicate hydrocodone was administered at 1:45 p.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 7:45 a.m., 1:45 p.m. and 8:30 p.m.</p> <p>-On 1-25-2014, the MAR lacked documentation to indicate hydrocodone was administered at 3:45 a.m. and 10:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 3:45 a.m., 10:00 a.m. and 6:36 p.m.</p> <p>-On 1-27-2014, the MAR lacked documentation to indicate hydrocodone</p>				

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	<p>was administered at 2:00 a.m. and the Controlled Substances Record indicated the hydrocodone was signed out at 2:00 a.m., 7:15 a.m. and 7:00 p.m.</p> <p>An interview with LPN #1 on 1-29-2014 at 2:00 p.m., indicated when a resident requested a prn narcotic pain medication, the nurse was to document the medication in the MAR and on the Controlled Substances Record.</p> <p>An interview with LPN #1 on 1-30-2014 at 9:40 a.m., indicated she was not aware some documentation was not entered on the MAR for the administration of the prn controlled substance medications signed out by the nurse. LPN #1 indicated there was not a double check system in place to reconcile the signed out controlled substances to be sure they were also documented on the MAR. An LPN #1 indicated she was not aware that Resident #132's Controlled Substance Record entries for clonazepam 1 mg dated 12-23-13, 12-26-13, 1-2-14, 1-3-14 and 1-23-14 indicated 1 tablet was signed out when the order was for 1/2 tablet (0.5 mg).</p> <p>An interview with LPN #6 on 1-30-2014 at 10:10 a.m., indicated when a resident requested a narcotic pain med, the medication was signed out on the</p>			

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	<p>Controlled Substance Record, administered to the resident and documented in the MAR.</p> <p>An interview with LPN #8 on 1-30-2014 at 10:30 a.m., indicated when a resident requested a narcotic pain med, she would assess their pain, review the orders, obtain the narcotic pain medication and sign out the narcotic on the resident's Controlled Substance Record and record the administration of the narcotic in the MAR.</p> <p>An interview with RN #7, the Rehabilitation Manager on 1-30-2014 at 11:25 a.m., indicated she was made aware on 1-29-2014 that there were discrepancies between the documentation on the Controlled Substance Record and the MAR.</p> <p>4. On 1/23/14 at 5:30 P.M., the narcotics from the medication cart on the Rehabilitation unit were observed. The unit manager had held the medication card of Resident #234 and was observed to have a total of 8 pills of Oxycodone-apap-5-325mg on it. LPN #9 was reading the controlled substance log. The log indicated there were 7 pills on the card. The log was observed at the</p>			

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	<p>time to begin with a total of 12 pills. On 1/22/14, 1 pill was given and there was a total of 11; on 1/22/14 another pill was given and a total of 10 was documented; on 1/23/14 1 pill was signed out and a total of 8 was documented; on 1/23/14 at 5:20 P.M. a total of 7 pills were documented. When LPN #9 was made aware of the discrepancy in the pill count versus the log and also the number of quantity of pills out of sequence, LPN #9 indicated "it's a math problem." LPN #9 then wrote over the "8" under quantity to make an "9" and she wrote over the "7" to make an "8". Documentation was lacking of the alteration in documentation as to when the alteration was made and by whom.</p> <p>On 1/24/14 at 9 A.M. the DON (Director of Nursing) was interviewed. She indicated the facility had inserviced all staff that have worked since yesterday about counting narcotics. She stated they have also counted all the controlled medications in the facility and the counts "were ok." At the time, she also provided a copy of the "In-Service Training/Attendance Record." This form dated 1/24/14 and included the following "Summary of Content": "All narcotics must be counted and signed of (sic) on in the narcotic log book with each shift change in staffing (sic). No exceptions."</p>			

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	<p>On 1/29/14 at 4:40 P.M., the Nurse Consultant, provided the controlled substance record and MAR (Medication Administration Record) for Resident #74. For the time frame of 1/2/14 to 1/29/14, the Controlled Substance Record (CSR) had documented the resident had 12 pills of Hydrocodone-APAP 5-325 mg signed out. When the CSR was compared to the MAR, there were 5 pills that were signed out on the CSR but were not accounted for and documented as given on the MAR.</p> <p>On 1/30/14 at 10:00 a.m., the DON (Director of Nursing) was interviewed regarding her investigation of the discrepancy of the Tramadol with Resident #74 on 1/23/14. She indicated the nurse, LPN #13, had signed the medication Tramadol 50 mg off of the Controlled Substance log on 1/23/14 at 2 P.M. (leaving 25 pills on the log) but had not removed the pill from the medication card (leaving 26 pills on the card). The DON indicated LPN #13 documented (on the MAR) the medication was administered to the resident on 1/23/14 at 2 P.M.</p> <p>On 1/30/14 at 10:15 a.m., the DON provided copies of the Education Notice given to LPN #13. The form included,</p>			

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	<p>but was not limited to, the following: "Failure to follow specific work related instructions...Narcotic count not correct. Medication documented in (name of facility medication administration record) et (and) not administered et cart not counted between shifts..."</p> <p>At the time, the DON also provided a copy of the interview with LPN #13. This form indicated LPN #13 did not give the pill to Resident #74 on 1/23/14, nor did she count narcotics before she left her shift.</p> <p>On 1/29/14 at 11:51 A.M., the DON provided copies of Resident #234's medication card (med card) (from the controlled substance portion of the medication cart) for Oxycodone-APAP 5/325 mg and the controlled substance record for this medication. The following 4 entries had been documented by RN #14 on the CSR for Resident #234 but the all the entries, had been crossed through with "ER" written beside RN#14's initials: 1/27/14 at 11 P.M. 1 pill; qty (quantity) remained of 26; 1/27/14 at 10 P.M. (sic) 1 pill; qty remained of 25; 1/28/14 at 2 A.M. 1 pill; qty remained of 24; 1/28/14 at 6 A.M. 1 pill;</p>			

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	<p>qty remained of 26 (sic); 1/29/14 at 11:10 A.M. 2 pills wasted due to package opened, 25 pills remained. This entry was witnessed by two nurse, one being the Unit Manager of the Rehab unit.</p> <p>On 1/29/14 at 11:51 A.M., the DON also provided a copy of the log nursing signed when the narcotics were counted at shift change for the rehab unit for January 2014. For the date of 1/28/14 at 7 A.M., LPN #9 initialed as the oncoming nurse but documentation was lacking of RN #14 as the off going nurse. At 3 P.M., LPN #9 initialed the areas for both the oncoming nurse and the off going nurse. The 11 P.M. blanks for oncoming and offgoing nurse were left blank. On 1/29/14, LPN #9 initialed as the oncoming nurse but documentation was lacking of an offgoing nurse.</p> <p>On 1/29/14 at 11:52 A.M.,the DON was interviewed and indicated the areas left blank on the nursing narcotic reconciliation log, were due to nurses working over 8 hour shifts. She indicated nurses only count the carts when they are done working on a cart.</p> <p>On 1/29/14 at 4 P.M., the MAR and Controlled Substance sign out logs for January 2014 were reviewed for Resident</p>			

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	<p>#234. The following observations were made: from the dates of 1/8/14 - 1/25/14, there were a total of 37 entries on the controlled substance record to sign out medications. Of the 37 narcotic log entries, 22 of the signed out narcotic oxycodone doses were not documented as given and/or refused on the MAR.</p> <p>On the date of 1/15/14, documentation on the MAR indicated Resident #234 was medicated at 7:40 A.M. with oxycodone 5 mg-325 mg, 1 tablet. Documentation was lacking on the controlled substance record that this medication had been signed out for her.</p> <p>Also noted, the entries on the narcotic sign out log for 1/27/14 (2 entries) and 1/28/14 (1 entry at 2 A.M.), in which RN #14 drew lines threw her entries and indicated the resident refused the medication at these time, documentation was lacking on the MAR of the resident's refusal. On 1/28/14, at 6 A.M., a line was drawn through the entry on the controlled substance log but was documented on the MAR as been given by RN #14.</p> <p>On 1/30/14 at 8:50 A.M., the DON was interviewed regarding the documentation from RN #14 on the oxycodone log for Resident #234. She indicated she had</p>						

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	<p>interviewed RN #14 and RN #14 indicated the reason for the lines drawn through the 4 entries on the log (2 entries on 1/27/14 and 2 on 1/28/14) were because the resident indicated she wanted a pain pill and then refused it.</p> <p>On 1/30/14 at 10:15 A.M., the DON provided another copy of the narcotic reconciliation log the nurses sign at shift change when the narcotics are counted was received for the Rehab unit for January 2014. This was compared to the narcotic reconciliation log that was received on 1/29/14 at 11:51 A.M. from the rehab unit. Documentation on both forms were compared for the dates of 1/21/14 to 1/27/14 to verify these were copies of the same form. When the copy received on 1/30/14 was reviewed, the dates of 1/28/14, oncoming nurse at 11 P.M. and offgoing nurse at 7 A.M. on 1/29/14 now had an illegible scribble in them.</p> <p>5. On 1/29/14 at 10:20 A.M., copies of Resident # 230's MAR and controlled substance log for the narcotic medication Hydrocodone-APAP 5-325 mg were received from the DON. The Controlled substance log indicated the following:</p> <p>A. On 1/17/14 at 2 P.M., a quantity of 24 was documented. On 1/17/14 at 6 P.M.,</p>			

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	<p>two pills were signed out and a quantity of 24 (sic) pills were documented. On 1/16/14 at 11:55 P.M., the CSR indicated 2 pills of hydrocodone had been signed out but the MAR indicated for 1/16/14 at 11:30 P.M., 1 pill of hydrocodone was administered to Res #230.</p> <p>B. On 1/17/14 at 7:53 A.M., the MAR indicated the resident refused 1 pill of hydrocodone. The CSR is lacking documentation of the medication being signed out.</p> <p>C. The following dates and times were documented on the CSR but documentation was lacking on the MAR that the medication had been given to Resident #230: 1/17 at 2 P.M. and 6 P.M.; 1/18 at 12 A.M.; 1/19 at 4 P.M. and 8 P.M.; 1/20 at 3:30 A.M.; 1/21 at 12:30 A.M.; 1/22 at 11 P.M.; 1/23 at 3 A.M.; 1/26 at 2 A.M. and 1/27 at 4 A.M.</p> <p>D. A dose documented as given on the MAR on 1/22 at 12:28 P.M. lacked documentation on the CSR of having been signed out.</p> <p>On 1/30/14 at 8:37 A.M., the DON was interviewed. She indicated the facility was in the beginning stages of the investigation of the discrepancy with narcotics. She indicated the Rehab unit</p>			

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	<p>was the biggest concern and this was where they started their investigation. She indicated they had reconciled the drugs on the rehab unit and the narcotics as to what had and had not been documented. She indicated she had looked for patterns. She indicated this was as far as they got last night. The DON indicated they found some inconsistencies and some things they need to work on. The DON indicated they have issues that need to be corrected and they will take longer than one night to investigate. At the time, the DON was unable to account for the medications which had been signed out from the CSR but not documented as given. She indicated when a line is drawn through an entry, it should be initialed, dated and timed.</p> <p>On 1/29/14 at 4:11 P.M., the Nurse Consultant provided a current facility policy and procedure for "Safeguarding Controlled Substances." This policy was dated 1/09. The policy included, but was not limited to, the following: "Practice: Each facility will engage in safe and secure practices related to appropriately receiving, storing, administering, reconciling and safeguarding controlled substances...Administration of controlled medications: The licensed nurse is to immediately enter the following</p>			

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	<p>information when removing dose(s) from controlled storage on the resident's individual controlled substance accountability record:...amount of medication remaining, signature of nurse removing the medication; Following removal and administration, the nurses is (sic) to document on the residents MAR (medication administration record) the date, time, and reasons (if PRN (as needed) a controlled substance had been given; Following removal of dose(s) which were not administered for whatever reason; the medication must be destroyed (wasted) by 2 Licensed Nurses per facility disposal procedure; both nurses must witness and sign to legally attest the destruction. Reason for the disposal should accompany the signatures, such as "dose refused"..on the control accountability record on the line representing that dose and signed by both licensed nurses. Do Not Replace back into the container or package; Controlled Drug Count/Change-of-shift Reconciliation: Each individual controlled substance must be counted when there is a change in shift nurse; The on-coming licensed nurse will view and verify each medication supply and amount(s) remaining, while the off-going nurse calls out the resident name, medication and amounts remaining on controlled logs. The count should be</p>			

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F000520 SS=E	<p>completed in a diligent manner and the oncoming nurse should examine tablets and medications carefully during the count...Both on-coming and off-going licensed nurses will sign the controlled drug count verification form when deemed accurate. At this time, the on-coming nurse may assume the keys.</p> <p>3.1-50(a)(1)</p> <p>h</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p>			

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	<p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility failed to implement an action plan for the identified concerns regarding staff handwashing during meal service, taking the food temperatures just prior to the start of meal service, ensuring cold foods were held at the proper temperature during the meal service, ensuring the dietitian's recommendations were implemented, and ensuring the Controlled Substance Record documentation for residents with as needed pain medications matched the Medication Administration Record for those residents which had the potential to affect the 113 of 113 residents who resided at the facility.</p> <p>Findings include:</p>	F000520	#1 This facility will identify and implement a plan of action for identified concerns of staff handwashing during meal service, taking food temperatures prior to start of a meal service, ensuring the cold foods are held at the proper temperature during meal service, dietitian's recommendations were implemented, and ensuring the Controlled Substance Record documentation for residents with PRN medications match MAR.#2 Staff will be inserviced on 2/25/2014 and action plans will be developed. Action plans to address handwashing during meal service, taking food temperatures prior to start of a meal service, ensuring the cold foods are held at the proper temperature during meal service, dietitian's recommendations were implemented, and ensuring the	03/01/2014

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	<p>An interview with the Administrator on 1-30-2014 at 12:49 p.m., indicated he would have to check to see if they were aware of the documentation issues and handwashing and food temperature concerns.</p> <p>An interview with the DON (Director of Nursing), Administrator, and Corporate Nurse on 1-30-2014 at 2:00 p.m., indicated they were aware of the staff handwashing concerns during dining, taking the food temperatures prior to meal service concern, and were aware of the lack of communication concerns with nursing regarding the implementation of the dietitian's recommendations, but were not aware of the concerns with ensuring cold foods were held at the proper temperature during the meal service and the concern with the Controlled Substance Record for the PRN (as needed) narcotic pain medications with the narcotics being signed out, but not being documented in the MAR (Medication Administration Record).</p> <p>The QA committee failed to implement an action plan to correct and monitor the staff handwashing concerns during dining, the taking of temperatures prior to the meal service concern and the communication concerns between the</p>		<p>Controlled Substance Record documentation for residents with PRN medications match MAR.#3 Staff to be inserviced 2/25/2014 on proper handwashing during meal service. #4 DSD/designee will perform 5 random observations of proper handwashing technique during meal pass. Temperature Log Book will be monitored 3 times a week for a month, then weekly for 3 months, thereafter monthly times 3 months. UM/designee will monitor dietary recommendations to make sure they are completed weekly. UM/ Designee will audit all PRN Contolled Substance Sheets, shift to shift narcotic count sheets, and Administration records for completion, 5 times weekly for 4 weeks, then one time a week times 3 months, then one time a month for 3 months, thereafter monthly. Pharmacy Tech will continue to do random checks on a quarterly basis to continue to audit for compliance. Results of audits will be forwarded to QA committee for tracking and trending monthly for a minimum of 6 months.#5 Systematic changes will be completed by 3/1/2014.</p>	

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	<p>dietitian and nursing to ensure the dietitian's recommendations were being implemented. The QA committee failed to address and develop an action plan to ensure cold foods were held at the proper temperature during the meal service and to ensure the Controlled Substance Record for the PRN narcotic pain medications with the narcotics being signed out, were being documented in the MAR.</p> <p>On 1-30-2014 at 2:45 p.m., a QA (Quality Assurance) policy was requested from the DON but not provided.</p> <p>3.1-52(a)(2)</p>			