

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2013
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NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
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F000000	<p>This visit was for the Investigation of Complaint IN00138825. This visit was done in conjunction with a Recertification and State Licensure Survey.</p> <p>Complaint IN00138825 - Substantiated. Federal/state deficiencies related to the allegation(s) are cited at F309 & F241.</p> <p>Survey date(s): October 28, 29, 30, 31, & November 1, 2, 3, 4, 5, 2013</p> <p>Facility number: 000131 Provider number: 155226 AIM number: 100274910</p> <p>Survey team: Lora Brettnacher, RN-TC (October 28, 29, 30, 31, & November 2, 3, 4, 5, 2013) Jeanna King, RN Karen Hartman, RN (October 28, 29, 30, 31, & November 1, 2, 3, 5, 2013)</p> <p>Census bed type: SNF: 8 NF: 99 Total: 107</p>	F000000	We are requesting face to face IDR for F309. We disagree with the severity.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>Census payor type: Medicare: 8 Medicaid: 87 Other: 12 Total: 107</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on 11/13/13 by Brenda Marshall Nunan, RN.</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure privacy was maintained during medication administration for 1 of 7 residents observed for dignity during medication pass (Resident #72).</p> <p>Findings include:</p> <p>Resident #72's record was reviewed on 11/1/2013 at 1:00 P.M. Resident #72 had diagnoses which included, but were not limited to, malnutrition, anemia, and ventilator dependent. A quarterly Minimum Data Set Assessment Tool (MDS) dated 9/4/13, indicated Resident #72 was cognitively impaired.</p> <p>During observations of medication administration on 11/1/13 at 12:36 PM, Registered Nurse (RN) #100 was observed to administer medication to Resident #72 via her gastrointestinal tube. RN #100 failed to pull the curtain and/or shut the resident's door to ensure dignity and privacy were maintained during care. Resident</p>	F000241	<p>F241It is the practice of this provider to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. What corrective action will be accomplished for those residents found to have been affected? The privacy curtain was drawn and the door was closed, for Resident #72, during subsequent medication administrations. How other residents will be identified and what correction action taken? All residents with gastrointestinal tubes who receive medication have the potential to be affected by the alleged deficient practice. Continuing Education Coordinator performed medication administration observations for these residents to ensure that each resident's dignity and respect were maintained. What systemic changes will be made to ensure the deficient practice does not recur? RN #100 received additional training and skills validation utilizing the "Enteral tube-Medication Validation" tool. All staff in-serviced on 11/12/13 and 11/26/13 by Clinical Education Coordinator regarding</p>	11/27/2013	

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	<p>#72 was uncovered with her legs and abdomen exposed.</p> <p>During an interview on 11/5/2013 at 2:00 P.M., the DON (Director of Nursing) indicated RN #100 had informed her she failed to maintain Resident #72's privacy during a medication administration and it was the facility practice to ensure privacy and dignity were maintained at all times.</p> <p>This Federal tag relates to complaint IN00138825.</p> <p>3.1-3-(t)</p>		<p>dignity. Each resident will be monitored daily by assigned customer care representatives, who will assess to ensure residents' dignity is being maintained. Deficient practices will immediately be brought to the attention of the nurse manager providing care for the resident and immediate corrective action will be taken. DNS/designee will conduct rounds daily on each shift to ensure residents are provided with dignity during medication administration. How the corrective action will be monitored? A dignity CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by a nurse manager or designee. The dignity audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 11.27.2013</p>		

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F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>1a. Based on interview and record review, the facility failed to ensure a resident with urinary retention, a Foley catheter, and on antibiotics for a urinary tract infection was adequately assessed/monitored for changes in health status; and</p> <p>1b. The facility failed to ensure a resident on an antibiotic for aspiration pneumonia was adequately assessed/monitored for changes in health status resulting in hospitalization for a critical illness for 1 of 8 residents reviewed for hospitalization (Resident #56).</p> <p>2. Based on observation, interview, and record review, the facility failed to effectively manage a resident's pain by failing to administer pain medication as ordered and failing to subjectively assess for efficacy following administration of pain medication for 1 of 2 residents reviewed for pain control (Resident #86).</p>	F000309	F309We are requesting IDR related to severity of the deficiency. It is the practice of this provider to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. What corrective action will be accomplished for those residents found to have been affected? Resident #56 no longer resides at the facility. New pain assessment was completed for resident #86. Resident #86 also received medication and diagnoses review by Physician/NP. An audit was performed to ensure resident is receiving pain medications as ordered by the nurse manager by reconciling the MAR with the physician orders. How other residents will be identified and what correction action taken? All residents with indentified changes in condition have the potential to be affected by the alleged deficient practice. An audit was performed of residents who	11/27/2013	

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	<p>Findings include:</p> <p>1a. Resident #56's record was reviewed on 11/4/2013 at 9:11 A.M. Resident #56 was admitted to the facility on 8/29/2013, and had current diagnoses which included, but were not limited to, diabetes mellitus type II, hypertension, pain, anxiety, bladder outlet obstruction, gross hematuria (blood in urine), urinary retention, prostate hypertrophy, renal failure, anemia, dementia, trauma classified skin tears to the right and left posterior meatus with no symptoms of infection, and ALS (Lou Gehrig's Disease).</p> <p>Admission vitals recorded on 8/29/2013 at 10:02 P.M., indicated Resident 56's oxygen saturation (O2 sat) was 98% on room air, blood pressure (b/p) 108/68, respirations (R) 18 per minute, and his pulse was 99 beats per minute. An admission nursing assessment note dated 8/30/2013 at 12:45 A.M., indicated Resident #56 was alert and oriented to person and place, incontinent of urine, and had clear breath sounds without respiratory distress.</p> <p>A social service note dated 9/4/2013 at 2:30 P.M., indicated Resident #56</p>		<p>experienced a change in condition relative to pain, respiratory assessment, urinary output, and labs by the nurse managers to ensure they were/are appropriately assessed/monitored for changes in their health status, that physician notification has been made, and that documentation of the assessment, monitoring, and notification was completed. What systemic changes will be made to ensure the deficient practice does not recur? In-servicing was completed for licensed nurses on 11/12/13 and 11/26/13 by the Clinical Education Coordinator, Registered Dietician, and the Respiratory Manager relative to condition change, laboratory services, pain management, urinary output documentation and respiratory assessments. All ordered labs will be placed on the lab tracker. DNS/designee will ensure labs are drawn as ordered, MD notified, and follow-up completed by following the new lab tracking process. All residents who have refused labs will prompt notification of the MD and family, with documentation to support notification. Nurses assigned to residents with Foley catheters will print input and output reports every shift and review for completion and accuracy. DNS/designee will review the reports on a weekly basis to ensure all residents with Foley catheters have</p>				

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	<p>was cognitively intact with a BIMs (Brief Interview Mental Status assessment) score of 13 and was a full code.</p> <p>A nurse's note dated 9/5/2013 at 2:57 P.M., indicated Resident #56 had to be catheterized via an in and out catheter due to urinary retention with eight hundred ml (milliliters) of dark, amber, cloudy, urine noted.</p> <p>An untimed telephone physician's order dated 9/5/13, indicated orders for a midline (peripheral venous access device) to be placed "ASAP" (as soon as possible), IV (intravenous) antibiotics, and IV fluids for the diagnoses of leukocytosis/suspect UTI (urinary tract infection).</p> <p>A nurse's note dated 9/5/2013 at 6:30 P.M., indicated Resident #56 was catheterized due to urinary retention. The nurse performed I/O (In and out catheter) and noted "1200 mls" of "very dark reddish-black urine with very bad odor."</p> <p>A nurse's note dated 9/6/2013 at 8:56 A.M., indicated the facility notified the physician regarding Resident #56's urinary retention. The physician gave orders to anchor a Foley</p>		<p>documentation present of the amount of urine obtained from Foley catheters every shift. All residents upon admission and at the time a new order is received will have IDT review. IDT will ensure, during physician order review process, that every resident with an order for oxygen therapy will have an order to monitor O2 saturation every shift.</p> <p>Pain management assessments will be done at the time of admission and assessed weekly during weekly skin assessments, as well as every day throughout the course of each shift and documented on the MAR and/or in the nurses' notes when applicable. This will be completed by licensed nurses. MD and family will be notified of change of condition/pain. Physician orders will be followed as given. Monitoring will be done of the resident for effectiveness of pain management interventions.</p> <p>Deficient practices will immediately be brought to the attention of the Director of Nursing Services and immediate corrective action will be taken. How the corrective action will be monitored? Change of condition, refusal of medication and treatments, oxygen therapy, pain management, and catheter assessment CQI audit tools will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly</p>		

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	<p>catheter, start IV fluids, and ordered a BMP (basic metabolic panel) to be drawn on 9/7/2013.</p> <p>The record lacked documentation the BMP lab was obtained. The record lacked documentation which indicated staff assessed Resident #56's urine and/or monitored his urine output on the following dates: 9/6/2013, 9/7/2013, 9/10/2013, 9/14/2013, and 9/16/2013.</p> <p>During an interview on 11/5/2013 at 10:13 A.M., the DON indicated the facility did not have documentation which indicated the lab company had attempted to obtain the ordered lab prior to 9/11/2013. The DON indicated the lab informed her they attempted to obtain the lab on 9/11/2013 however Resident #56 refused three times so they did not attempt again. The facility did not notify the doctor the lab had not been drawn the day it was ordered. The DON indicated on 9/12/2013, when the facility realized the lab had not been drawn, the physician was notified and he reordered the BMP to be drawn on 9/13/2013.</p> <p>A lab report record dated 9/13/2013 at 3:01 P.M., indicated a BMP lab was obtained from Resident #56.</p>		<p>for three months by a nurse manager or designee. The change of condition, refusal of medication and treatments, oxygen therapy, pain management and catheter assessment audit tools will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of compliance: 11.27.2013</p>				

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	<p>This document indicated a creatinine level of 0.5 low (normal ranges of 0.6 to 1.3) and a BUN/CREAT RATIO of 48 high (normal ranges 6-25). A comparison result drawn on 9/5/2013, indicated a creatinine level of 0.6 and a BUN/CREAT RATIO of 37. This report indicated a decline in Resident #56's status.</p> <p>During an interview with the Director of Nursing (DON) and the Executive Director (ED) on 11/4/13 at 1:34 P.M., the DON indicated if a resident had a Foley catheter urine needed to be measured.</p> <p>During an interview on 11/5/2013 at 2:00 P.M., the DON indicated after Resident #56 had a Foley catheter inserted due to urinary retention and antibiotics for a urinary tract infection, staff did not consistently monitor urine output and/or assess Resident #56's urine.</p> <p>A document titled "American Senior Communities Medicare Documentation Guideline" dated 10/09, provided by the DON on 11/4/2013 at 1:41 P.M., indicated, ".... recommended documentation to support daily skilled services.... Urinary/Urinary Tract Infection: Hydration status, description of</p>						

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	<p>urine-color, odor, consistency, S/S (signs/symptoms)-chills, nausea, vomiting, flank/abdominal pain, fever, malaise, frequency, urgency, dysuria, mental status change, administration of antibiotics, resident response, side effects, presence of catheter-insertion, irrigation, replacement...."</p> <p>1b. A nurse's note documented on 9/17/2013 at 3:39 A.M. for events that occurred on 9/16/2013, indicated, "...writer came on shift at 2 pm at that time resident continued with ABT(antibiotic), but showed no S/S of any distress. At 3 pm (sic) aide had writer help transfer resident to shower chair. While in shower resident experienced resp. (respiratory) distress. Writer helped aide return resident to his bed. At that time V/S (vitals) were (temperature) 96.8 (degrees Fahrenheit) (blood pressure) 108/68 (pulse) 124 (oxygen) 02 sat (saturation) 82% and resp. rapid and labored at 24. Writer obtained O2 and was able to increase O2 sat to 88 % on 4 liters. resident (sic) was also suctioned at this time, writer obtained a large amount of very thick white mucus with particles of food imbedded in it. Writer called the MD and received new orders to change the current antibiotic to..., Stat</p>			

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	<p>(immediately) Chest X-ray, for possible asperation [sic].... Through out the night resident has shown a steady decline, but has remained responsive. V/S (vitals) at this time (temperature) 96.6, (blood pressure b/p) 112/64 (pulse) 110 (oxygen saturation) 88% on 4 liters O2, (respirations) rep. rapid and shallow at 26, blood sugar 86. Will continue to monitor."</p> <p>A physician's telephone order dated 9/16/2013 at 6:00 P.M., indicated orders which included a stat chest x-ray and for O2 (oxygen) as needed to keep Resident 56's oxygen saturations above 90%. The chest x-ray results, received on 9/17/13, indicated an early infiltrate in the right upper lung field.</p> <p>The record lacked documentation to indicate lungs sounds/respiratory status were assessed following identification of the infiltrate. The record lacked documentation to indicate oxygen saturation was monitored and interventions implemented to ensure Resident 56's oxygen saturation was maintained above 90% per the physician's order and/or the physician was notified of Resident #56's "steady decline."</p>			

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	<p>An ED (Emergency Department) Progress Note, dated 9/17/13 at 1:05 p.m., indicated, "...from ECF (Extended Care Facility) per EMS (Emergency Medical Services) for difficulty breathing...breathing slowly and hypoxic...with GCS (Glasco Coma Scale) of 4. Gross hematuria...SBP (systolic blood pressure) 70...lack of responsiveness...In the ED foley catheter changed over and urine appears frankly purulent...acute renal failure, metabolic acidosis, hyperkalemia...."</p> <p>An emergency room physician's report dated September 17, 2013 at 1:13 P.M., indicated, "...At facility was being treated for possible aspiration pneumonia w(with)/rocephin. Facility y staff noted patient to be less responsive than baseline this am, and called EMS. He was noted to have a fentanyl patch on, ems removed and administered 0.4 narcan. On arrival patient is breathing slowly w/a (with a) GCS (Glasco Coma Scale) of 4. SBP (systolic blood pressure) of 117. Intubated for... inability to protect airway....Respiratory Rate 24 br/min (beats per minute) Hi...Severe distress, ill-appearing... Respirations: Respiratory distress moderate, labored...glasgow coma scale (GCS):</p>			

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	<p>Total score 4..." This report indicated Resident 56's arterial blood gas results indicated his oxygen saturation was low at 84%.</p> <p>A late entry nurse's note documented after Resident #56 was sent to the emergency room dated 9/17/2013 at 2:38 P.M., indicated, "Res was not given his scheduled morning narc (narcotic) due to him being transferred to the ER. Res had noted blood in his urine; no abdomonal [sic] distension noted at the time. Res skin has continued to be clammy and sweaty since this mornings rounds. Treatment to non pressure wounds were completed as oedered [sic]. Res was sent out to the ER around noon due to low stats [sic]..."</p> <p>An acute care hospital critical staff progress note dated September 17, 2013 at 3:17 P.M., indicated Resident 56 had been admitted from the emergency room for, "...urosepsis secondary to obstruction at prostatic site admitted from ER for ams (altered mental status)/SHOCK/aCUTE RENnal [sic] failure, hyperkalemia.... Dependent pulmonary opacities may represent aspiration or infection...impression and plan... Neuro/Psych...Likely a combo of Infection/Sepsis/Renal</p>						

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	<p>failure multiple sedative pain meds on board...dialysis...Borderline BP with Lactic acidemia, WEBC [sic] count-- -Possible source PICC/URINE/?/Pneumonia.... Pulmonary Intubated for airway protection, being hyperventilated for maintaining PH... Bibailar atelectasis/Aspiration+Pneumonia....I nfectious Disease Sepsis secondary to Line infection vs Urine vs Pneumonia... Significant leucocytosis-Sepssi [sic] most likely dehydration is a possibility... altered mental status... Hypotension...Aspiration pneumonitis...Hypoxemia..., Pulmonary insufficiency... Acidosis..., Hyperkalemia... Renal failure... systemic inflammatory response syndrome (SIRS)... Urinary tract infection...critically ill patient....."</p> <p>A nurse's note dated 9/17/2013 at 4:24 P.M., indicated, "writer notified by ER nurse res was admitted with urosepsis and acute renal failure"</p> <p>During an interview regarding facility expectations for nursing care related to aspiration, on 11/4/2013 at 10:05 A.M., the Infection Control Nurse stated, "...I would absolutely expect lung assessments. I will see what policy we have but it is standard</p>						

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	<p>nursing for residents with aspiration." The Infection Control Nurse indicated Resident #56 was sent to the emergency room due to a low blood pressure and low O2 saturation. During this interview documentation of all lung assessments and vitals completed for Resident 56 were requested.</p> <p>During an interview with the Director of Nursing (DON) and the Executive Director (ED) on 11/4/13 at 1:34 P.M., the DON indicated the facility did not have a specific policy which indicated a nurse should do a lung assessment for residents being treated for respiratory infections but it was expected as a nursing standard of care. The DON indicated if a resident had orders to have their O2 sats maintained at a certain level oxygen saturation monitoring should have been done, at a minimum, of each shift. She indicated she would check but did not think the facility had a specific policy.</p> <p>A document titled "American Senior Communities Medicare Documentation Guideline" dated 10/09, provided by the DON on 11/4/2013 at 1:41 P.M., indicated recommended documentation to support daily skilled services.</p>						

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	<p>"...Pulmonary disease/Pneumonia/respiratory: Lung sounds, ability to cough and deep breathe, description amount of sputum, presence and type of cough, oxygen (liters/delivery)-tolerance, activity tolerance/endurance, episodes of dyspnea/apnea, changes in mental status, physician notification/order changed, edema-location, amount, interventions...."</p> <p>During an interview on 11/4/2013 at 1:41 P.M., the Executive Director indicated the American Senior Communities Medicare Documentation Guideline was not a facility policy. She further indicated it was a guide line recommended for skilled assessments and documentation for residents on Medicare. The ED indicated Resident #56 was not on Medicare but was on Medicaid therefore the skilled services and documentation were not required in his case.</p> <p>During an interview on 11/5/2013 at 2:00 P.M., the DON indicated after Resident #56 had aspirated and was started on antibiotics to treat aspiration pneumonia, documentation was not available which indicated his respiratory status was consistently</p>						

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	<p>assessed per standards of nursing care.</p> <p>During the exit conference on 11/5/2013 at 3:00 P.M., the DON and ED were asked if they had any further information or documentation. Both the DON and ED indicated they did not have further documentation or information regarding Resident #56.</p> <p>2. Resident #86's record was reviewed on 11/2/2013 at 10:30 A.M. Resident #86 had diagnoses which included, but were not limited to, back pain, joint pain, stiffness, gain instability, history of falls, gout, memory problems, and weakness. A quarterly Minimum Data Assessment Tool (MDS) dated 9/4/2013, indicated Resident #86 was cognitively intact with a BIMs (Brief Interview Mental Status) score of 15 out of 15.</p> <p>Physician orders dated 10/19/2013 indicated, "May have 2 mg/ml 0.75 ml every 4 hrs as needed for pain severe via gastro intestinal tube."</p> <p>During observations on 10/29/2013 at 9:43 A.M., Resident #86 was observed to repeatedly moan and rub his left leg. During an interview at this time, Resident #86 stated, "I've been trying to get medicine since 9:00."</p>						

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	<p>Resident was observed to point at the clock in his room. Resident #86 stated, "I have put on the light about a hundred times. My pain is a 10. The last time I had pain meds (medications) it was five A.M. It is in my left leg and foot." Resident #86 indicated the pain was so bad he couldn't stand for anyone to touch his leg even for bathing. At this time (10:00 A.M.), Licensed Practical Nurse (LPN) #8 entered Resident #86's room. LPN #8 stated, 'I will see if you have PRN (as needed) morphine. Things change. I was off.' Resident #86 stated, "I've been trying to get pain medicine for an hour." LPN #8 stated, "You had pain med at 6:00." Resident #86 stated, "It wasn't 6:00 it was 5:00." LPN #8 stated, "With him I go by how he acts. If he is up and around in his wheel chair then I know medicine is working. I don't go by what he says. I go by visual."</p> <p>During an interview on 10/29/2013 at 10:28 P.M., Unit Manager #9 indicated the facility utilized the 1:10 pain scale unless a resident was non-verbal." Unit Manger #9 indicated it wasn't for her to determine if they are not in pain. If the resident is verbal they use the pain scale.</p>						

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	<p>During an interview with the Director of Nursing (DON) and the Executive Director (ED) on 11/4/13 at 1:34 P.M., the DON indicated the pain scale used by the facility was in the policy and pain should be assessed before and after pain medication is given. Pain is what the patient says it is.</p> <p>The Medication Administration Record (MAR) for October and November 2013 indicated Morphine 20 mg/1 ml (0.75 ml) was administered to Resident #86 on the following dates and times:</p> <p>10/20/13 at 2 A.M. for complaints of severe pain. The record lacked documentation of the effectiveness of the pain medication.</p> <p>10/21/2013 at 10:00 P.M. for complaints of severe pain. A nurse's note dated 10/21/2013 at 10:02 A.M. indicated, "...pain meds given x 1 and was effective..." A nurse's note dated 10/21/2013 at 11:35 A.M., indicated, "resident continues to be very aggressive. resident was requesting for pain medication every hour."</p> <p>10/22/2013 at 2:00 A.M. "c/o generalized severe pain-effective." A</p>				

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	<p>nurse's note dated 10/22/2013 at 2:36 A.M. indicated, "res resting at this time. voiced c/o generalized pain and severe pain in bil (bilateral) feet d/t (due to gout. prn (as needed) given and effective...."</p> <p>10/22/2013 at 4:00 P.M. for "generalized pain." At 5:00 P.M. documentation indicated, "effective."</p> <p>10/23/2013 at 10:33 (AM or PM not specified)- for complaints of pain "7-feet and elbow." 11:33 effective "better."</p> <p>10/24/2013 at 10:40 P.M. complaints of "severe pain effective."</p> <p>10:24/2013 at 2:40 A.M. complaints "pain effective."</p> <p>10/26/2013 at 2:00 A.M. complaints of "pain in feet effective."</p> <p>A nurse's note dated 10/26/2013 at 2:47 A.M., indicated, "Resident compaines [sic] about nausea and pain in left lower part of leg. Resident was given Morphine-PRN. G-tube worked propertly [sic]. Resident most of night spent on the wheelchair."</p> <p>A nurse's note dated 10/26/2013 at 11:52 A.M., indicated, "resident c/o</p>			

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	<p>pain and nausea. res was given prn morphine and zofran. resident continued asking for more pain medicine. resident was redirected calmly and the [sic] he fell asleep." The MAR indicated the last time Resident #86 was given his PRN morphine was on 10/26/2013 at 2:00 A.M. (9 hours and 52 minutes earlier). The record lacked documentation PRN pain medication was given as ordered.</p> <p>10/26/2013 at 6:00 P.M. 1"10/10-severe foot pain-effective." A nurse's noted dated 10/26/2013 at 9:12 P.M., "res c/o (complaints of) pain severe pain to BLE (bilateral lower extremity) r/t (related to) gout x 1 this shift relieved by prn pain..."</p> <p>A nurse's note dated 10/27/2013 at 5:02 P.M., indicated a nurse called the nurse practitioner (NP) with "concerns" about Resident #86's "prn pain med, dose, and frequency of need for med." The NP gave a new order for "an increase in Tylenol 650 mg q (every) 6 hr (hours)." This note indicated, "...that MD will need to eval res for change in meds and communication will happen on Monday morning 10/28/2013."</p> <p>The record lacked documentation the</p>						

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	<p>the Tylenol was administered.</p> <p>10/28/2013 at 2:00 A.M. complaints of "left foot pain-8 out of 10." "Effective-2:30 A.M."</p> <p>10/28/2013 at 6:00 A.M. complaints of "left foot pain-8 out of 10." "6:35 effective."</p> <p>10/29/2013 at 1:00 P.M. "severe pain-effective."</p> <p>A nurse's note dated 10/29/2013 at 3:26 P.M., indicated, "resident complained of pain several times during the shift, resident was seen by NP and new orders were given...."</p> <p>10/29/2013 at 5:00 P.M. "severe pain-effective."</p> <p>10/29/2013 at 2:00 A.M. "complaints of leg pain - 8 out of 10-effective 3AM."</p> <p>10/29/2013 at 6:00 A.M. "c/o (complaints) leg pain 8 out of 10." "Effective at 7 am."</p> <p>10/30/2013 at 10:00 A.M. "c/o leg pain - 8 out of 10-effective at 11 am."</p> <p>10/30/2013 (time not legible) "c/o severe pain" "Effective,"</p>			

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	<p>10/31/2013 at 2:00 P.M. "co pain." "Effective."</p> <p>10/31/2013 at 6:00 P.M. "c/o leg pain-effective at 6:30 P.M."</p> <p>10/31/2013 at 10:00 P.M. "c/o leg pain -8 out of 10-effective at 10:30 P.M."</p> <p>A nurse's note dated 10/31/2013 at 8:07 P.M., indicated, "...Resident has requested pain medication q 4 hours...."</p> <p>11/1/2013 at 2:30 A.M. "Pain-effective 5:30 A.M."</p> <p>11/1/2013 at 2:00 P.M. "leg pain 8 out of 10-helpful-2:20 P.M."</p> <p>11/1/2013 at 6:00 P.M. "leg pain 8 out of 10-helpful-6:30 P.M."</p> <p>11/1/2013 at 10:00 P.M. "leg pain 8 out of 10-helpful-10:30 P.M."</p> <p>A nurse's note dated 11/2013 at 11:38 P.M., indicated, "...Prn morphine given [sic] at 2;00 [sic] pm, 6:00 pm and 10:00 pm, for C/O leg pain...."</p> <p>11/2/2013 at 2:30 A.M. "leg pain</p>			

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	<p>effective 3:30"</p> <p>A nurse's note dated 11/2/2013 at 7:23 A.M., indicted "resident complain of pain. PRN medication given as ordered with effect...."</p> <p>11/2/2013 at 11:00 P.M. "leg pain effective 12:02."</p> <p>11/2/2013 at 3:00 A.M. "leg pain effective 4a."</p> <p>11/2/2013 at 10:00 A.M. "pain in legs-up mobile wheel chair." The record lacked documentation of the effectiveness of the pain medication.</p> <p>11/2/2013 at 3:00 P.M. " pain in legs-up w/c mobile." The record lacked documentation of the effectiveness of the pain medication.</p> <p>11/2/2013 at 8:00 (A.M. or P.M. not indicated) "pain in feet-up mobile." The record lacked documentation of the effectiveness of the pain medication.</p> <p>11/3/2013 at (time not legible) "up w/c c/o foot pain-up mobile." The record lacked documentation of the effectiveness of the pain</p>						

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	<p>medication.</p> <p>11/3/2013 at 3:00 P.M. "...legs-up mobile."</p> <p>The record lacked documentation of the effectiveness of the pain medication.</p> <p>Resident #86's care plan dated 10/28/2013, indicated Resident 86 had a problem with pain and was at risk for pain related to Gout. A goal listed indicated Resident 86 would have pain relief within 30 minutes of intervention. Approaches listed to meet this goal included: Administer meds as ordered, document effectiveness of PRN medication, notify MD if pain is unrelieved and/or worsening, observe for non verbal signs of pain, offer non pharmacological interventions such as quiet environment, rest, shower, back rub, and/or reposition.</p> <p>The record lacked documentation which indicated the facility consistently documented Resident #86's level of pain, location of pain, the efficacy of the PRN pain medication, used a measurable method to determine the efficacy of the PRN medication, consistently administered PRN pain medication when indicated as ordered, and/or</p>						

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	<p>administered scheduled pain medication (Tylenol) as ordered.</p> <p>A facility policy dated 1/3/2013 and identified as current by the ED on 11/4/2013 at 11:05 A.M., indicated, "It is the policy of American Senior Communities to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, including pain management. it is the responsibility of the facility to ensure each resident is assessed for pain, and the efficacy of pain medication, while keeping the resident as comfortable and pain free as possible.... The following guidelines will be used when assessing pain. INTERVIEWABLE RESIDENT The pain management program will be determined based upon the resident's verbal response to the questions on the pain assessment/interviewable resident. Pain medications will be prescribed and given based upon the intensity of the pain as follows: MILD, MODERATE, SEVERE, VERY SEVER, HORRIBLE...The physician will be notified of changes in the resident's verbal and/or non verbal expressions of pain. Physician orders for pain medication will be prescribed based upon the resident's intensity of</p>						

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	<p>pain.... Residents receiving routine pain medication should be assessed each shift by the charge nurse during rounds and/or medication pass. Documentation of administration of ordered PRN pain medication will be initialed on the front of the Medication Administration Record (MAR). Additional information including, but not limited to reasons for administration, interventions, and effectiveness of pain medication will be documented on the back of the Medication Administration (MAR), or on the facility specific pain management flow sheet. A plan of care will be written with the initiation of pain medication and individualized to the resident, addressing potential side effects, limitations due to pain, behavioral symptoms, and alternative pain relief techniques. The licensed nurse will monitor the efficacy of the analgesia and keep the physician informed of any indicators of drug or dosage change as it relates to the resident's pain management...."</p> <p>During the exit conference on 11/5/2013 at 3:00 P.M., the DON and ED were asked if they had any further information or documentation. Both the DON and ED indicated they did not have further documentation or information regarding Resident #86.</p>						

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	<p>This Federal tag relates to complaint IN00138825.</p> <p>3.1-37(a)</p>			