

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/29/2013
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F000000	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 8/21/13.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00138635 - Substantiated. Federal/state deficiencies related to the allegations are cited at F225, F226, F282, F431, and F514.</p> <p>Survey dates: October 23, 24, 25, 28 &amp; 29, 2013</p> <p>Facility number: 000250 Provider number: 155359 AIM number: 100289980</p> <p>Survey team: Sue Brooker RD TC</p>	F000000	<p>Riverbend Health Care Center Brenda Lewis, HFA, MSM, Executive Director 7519 Winchester Rd. Fort Wayne, In 46819 260-747-9282 fax This Plan of Correction is submitted as a requirement of law and not as an admission of any wrong doing by the Care Center. Riverbend health Care Center is operated with the best interest of the residents who reside here.</p>	

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

TITLE

(X6) DATE

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

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	<p>Martha Saul RN Virginia Terveer RN Julie Call RN (October 24, 25, 28 &amp; 29, 2013)</p> <p>Census bed type: SNF/NF: 41 Total: 41</p> <p>Census payor type: Medicare: 1 Medicaid: 35 Other: 5 Total: 41</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 1, 2013 by Randy Fry RN.</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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 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</p>	F000225	F 225 The initial report was filed	11/20/2013			

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	<p>review, the facility failed to report an unusual occurrence of a discrepancy between prescribed schedule II narcotic medication and results of drug screens to the Indiana State Department of Health (ISDH) for 1 of 1 residents reviewed with drug screen discrepancies. (Resident D)</p> <p>Findings include:</p> <p>On 10/24/13 at 3 P.M., the clinical record of Resident D was reviewed. Diagnoses included, but were not limited to, the following: Muscle spasm, Lupus, Degenerative Joint Disease, nerve pain, Diabetes, Myofacial pain, chronic low back pain. The most recent MDS (minimum data set assessment) dated 9/9/13 included, but was not limited to, the following: total cognition score of 15, which indicated cognition was intact; "yes" been on a scheduled pain medication regimen; "yes" had pain frequently; "yes" pain made it hard to sleep, limited day to day activities and had an intensity of "10" (on a scale of 1 to 10, with 10 being the most severe pain).</p> <p>A progress note, date 10/16/13, from the (name of pain center) was reviewed on 10/25/13 at 10 A.M. This note included, but was not limited to,</p>		<p>on 10/28/2013 and the final reported on 10/29/2013 by the Executive Director. To address the accuracy of the laboratory results, the labs were rerun and the results were in line with administration of prescribed medication. The amphetamines that were originally reported as present were not present when the test was rerun. The findings were reviewed by the staff nurse and the Director of Clinical Services (DCS) and have been reported to the physician. 2 The clinical records of in-house residents having received narcotic pain medications in the last 30 days will be reviewed by the Interdisciplinary Team (IDT) to determine unidentified lab discrepancies and address any issues identified by November 18, 2013. 3 The Regional Director of Clinical Services (RDCS) will re-educate the Executive Director (ED) on the regulation F225, the facility's abuse policy and the Indiana State Department of Health Reportable Incidents Policy formerly the ISDH Reportable Unusual Occurrence Policy revised 1/15/2013 by November 18, 2013. The RDCS will re-educate the Department Heads on the regulation and the facility's abuse policy by November 18, 2013. The ED or the Director of Clinical Services will re-educate the staff</p>		

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	<p>the following: "...serum drug screen reviewed, meds prescribed not in urine and meds not prescribed in urine, inconsistent and patient being weaned from narcotics today. Opana (schedule II narcotic pain medication) not found in blood sample. Thus patient not receiving and will not be prescribed today. Percocet (opioid analgesic) being weaned over the course of 3 weeks...drug screen results sent with paperwork."</p> <p>On 10/25/13 at 2:40 P.M., LPN #2 was interviewed. She indicated she was caring for Resident D today. She indicated on the day of Resident D's October appointment (10/16/13) someone from the pain clinic had called her. She indicated the pain clinic told her they did blood work at the pain clinic and the results did not show Opana, which the resident was prescribed to take, but the results did show Hydrocodone (Controlled Substance Schedule III), which the resident was not prescribed. LPN #2 indicated the pain clinic indicated the "labs were off" and the facility needed to look into this. LPN #2 also indicated the DON (Director of Nursing) informed her that she (the DON) had received a message from the pain clinic as well.</p>		<p>on the facility's abuse policy emphasis will be placed on reporting alleged violations to be investigated by November 20, 2013. 4 Ten residents receiving narcotics will have their labs reviewed by the DCS/designee weekly times four weeks then monthly for five months. The findings will be brought to two quarterly Quality Assurance/Performance Improvement (QAPI) committee meetings. The QAPI committee will determine if further action is indicated.</p> <p>5 Compliance date: 11/20/2013</p>				

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	<p>On 10/25/13 at 2:51 P.M., the DON was interviewed. She indicated no one from the pain clinic ever called her. She indicated today was the first day she had seen the progress note from the pain clinic dated 10/16/13. The DON indicated she was not aware of any discrepancies with the resident's medications.</p> <p>On 10/28/13 at 4 P.M., the Administrator was interviewed. She indicated she was not made aware of the discrepancy regarding Resident D, involving the urine/blood drug screens and the medications the resident is ordered and documented as taken, until last Friday, 10/25/13. She indicated she had not reported the incident regarding Resident D to the Indiana State Department of Health (ISDH).</p> <p>On 10/28/13 at 4:20 P.M., a copy, from the facility plan of correction book, was received from the Administrator for the "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 policy also included, but was not limited to, the</p>						

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	<p>following: two incidents reported to the ISDH will be recorded and tracked or monitored to insure residents are receiving appropriate care and services."</p> <p>This deficiency was cited on 8/21/13 and the facility failed to implement the plan to correct the deficiency.</p> <p>3.1-28(a) 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 investigation and reporting of an unusual occurrence to the Indiana State Department of Health for 1 of 1 residents reviewed with a discrepancy in a drug screen. (Resident D)</p> <p>Findings include:</p> <p>On 10/24/13 at 3 P.M., the clinical record of Resident D was reviewed. Diagnoses included, but were not limited to, the following: Muscle spasm, Lupus, Degenerative Joint Disease, nerve pain, Diabetes, Myofacial pain, chronic low back pain. The most recent MDS (minimum data set assessment) dated 9/9/13 included, but was not limited to, the following: total cognition score of 15, which indicated cognition was intact; "yes" been on a scheduled pain medication regimen; "yes" had pain frequently; "yes" pain made it hard to sleep, limited day to day activities and</p>	F000226	F 226 The initial report was filed on 10/28/2013 and the final reported on 10/29/2013 by the Executive Director. To address the accuracy of the laboratory results, the labs were rerun and the results were inline with administration of prescribed medication. The amphetamines that were originally reported as present were not present when the test was rerun. The findings were reviewed by the staff nurse and the Director of Clinical Services (DCS) and have been reported to the physician. The clinical records of in-house residents having received narcotic pain medications in the last 30 days will be reviewed by the Interdisciplinary Team (IDT) to determine unidentified lab discrepancies and address any issues identified by November 18, 2013. The Regional Director of Clinical Services (RDCS) will re-educate the Executive Director (ED) on the regulation F226, the facility's abuse policy and the Indiana State Department of Health Reportable Incidents Policy formerly the ISDH Reportable Unusual Occurrence Policy revised	11/20/2013	

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	<p>had an intensity of "10" (on a scale of 1 to 10, with 10 being the most severe pain).</p> <p>A progress note, date 10/16/13, from the (name of pain center) was reviewed on 10/25/13 at 10 A.M. This note included, but was not limited to, the following: "...serum drug screen reviewed, meds prescribed not in urine and meds not prescribed in urine, inconsistent and patient being weaned from narcotics today. Opana (schedule II narcotic pain medication) not found in blood sample. Thus patient not receiving and will not be prescribed today. Percocet (opioid analgesic) being weaned over the course of 3 weeks...drug screen results sent with paperwork."</p> <p>On 10/25/13 at 1:35 P.M., the Regional RN was interviewed. She indicated she was aware that the pain clinic had informed the facility the results of a serum drug screen which indicated the resident was not receiving the narcotic medications she was prescribed and had evidence of narcotic medications in her drug screen the resident was not prescribed.</p> <p>At the time, the Regional RN indicated she wasn't sure if she had</p>		<p>1/15/2013 by November 18,2013. The RDCS will re-educate theDepartment Heads on the regulation and the facility's abuse policy byNovember 18, 2013. The ED or the Directorof Clinical Services will re-educate the staff on the facility's abusepolicy emphasis will be placed on reporting alleged violations to beinvestigated by November 20, 2013. Ten residents receiving narcotics willhave their labs reviewed by the DCS/designee weekly times four weeks thenmonthly for five months. The findingswill be brought to two quarterly Quality Assurance/Performance Improvement(QAPI) committee meetings. The QAPIcommittee will determine if further action is indicated. Compliance date:11/20/2013</p>		

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	<p>documented the September investigation. She also indicated she was unaware of the last time the pain clinic had talked to the facility, she indicated the floor nurses would know this.</p> <p>She indicated she was aware of concerns expressed from the pain clinic with Resident D and inconsistencies regarding the resident's drug screens and the medication she is prescribed to take. She also indicated she was unaware of the last time the pain clinic had talked to the facility. She indicated the floor nurses would know this.</p> <p>On 10/25/13 at 2:40 P.M., LPN #2 was interviewed. She indicated she was caring for Resident D today. She indicated on the day of Resident D's October appointment (10/16/13) someone from the pain clinic had called her. She indicated the pain clinic told her they did blood work at the pain clinic and the results did not show Opana which the resident was prescribed to take, but the results did show Hydrocodone (Controlled Substance Schedule III), which the resident was not prescribed. LPN #2 indicated the pain clinic indicated the "labs were off" and the facility needed to look into this. LPN #2 also</p>			

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	<p>indicated the DON (Director of Nursing) informed her that she (the DON) had received a message from the pain clinic as well.</p> <p>On 10/25/13 at 2:51 P.M., the DON was interviewed. She indicated no one from the pain clinic ever called her. She indicated today was the first day she had seen the progress note from the pain clinic dated 10/16/13. The DON indicated she was not aware of any discrepancies with the resident's medications.</p> <p>On 10/28/13 at 8:55 A.M., the Administrator provided a copy of documentation provided to her by the Regional RN after the state agency left the facility on 10/25/13, 3:45 P.M. The documentation was undated, untimed and not signed. The documentation included, but was not limited to, the following information: "On September 10, 2013, resident returned from visit to the pain clinic and was very upset...CNA (certified nursing assistant) stated the pain clinic indicated the resident's drug screen was negative; therefore, she could not be receiving her pain medications...they (pain clinic) were going to decrease her dosages. Resident was very upset..."</p>						

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	<p>On 10/28/13 at 4 P.M., the Administrator was interviewed. She indicated she was not made aware of the discrepancy regarding Resident D, involving the urine/blood drug screens and the medications the resident was ordered and documented as taking, until last Friday, 10/25/13. She indicated she had not reported the incident regarding Resident D to the Indiana State Department of Health (ISDH).</p> <p>On 10/28/13 at 4:20 P.M., a copy, from the facility plan of correction book, was received from the Administrator for the "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 policy also included, but was not limited to, the following: two incidents reported to the ISDH will be recorded and tracked or monitored to insure residents are receiving appropriate care and services."</p> <p>On 10/29/13 at 1:25 P.M., the Administrator, DON (Director of Nursing) and Regional Director of Clinical Services were interviewed</p>			

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	<p>regarding the discrepancies with Resident D. The Administrator indicated she was unclear as to why this would be a reportable incident. She indicated the facility had a urine drug screen done on Resident D on 10/25/13. These results indicated the resident showed positive for Opiates and also Amphetamines. At this time, the Administrator, DON and Regional Director of Clinical Services were made aware the resident was not on any medications of the Amphetamine type. The Administrator indicated they had contacted the clinical head of the company in response to the most recent urine drug screen. She also indicated she would fax a report of the concerns with the resident to the ISDH today.</p> <p>This deficiency was cited on 8/21/13 and the facility failed to implement the plan to correct the deficiency.</p> <p>3.1-28(d)</p>			

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F000282 SS=D	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.	F000282	F 282 1.) Residents D and C showed no apparent adverse effects. Residents D and C's Physicians and Responsible parties were notified of medication administration discrepancies by the DCS on November 15, 2013 and any new orders given to the nurse by the physicians were received, noted, and implemented at that time. 2.) All residents have the potential to be affected. In-house residents will have their current physician's orders and medication administration records (MAR) reviewed by a member of the IDT to identify and address discrepancies by November 18, 2013. 3.) The RDCS re-educated the Department Heads on the regulation F282 and the facility's physician orders policy on 11/12/2013. In-house residents will have their current physician's orders and medication administration records (MAR) reviewed by a member of the IDT to identify and address discrepancies by November 18, 2013. The DCS or designee will re-educate the staff nurses on physician orders by November 20, 2013. 4.) Ten residents will	11/20/2013	

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	<p>Based on interview and record review, the facility failed to ensure physician orders were followed for 2 residents (Resident D and Resident C) of 13 residents reviewed for physician orders.</p> <p>Findings include:</p> <p>1. On 10/24/13 at 3 P.M., the clinical record of Resident D was reviewed. Diagnoses included, but were not limited to, the following: Muscle spasm, Degenerative Joint Disease, nerve pain, Diabetes, Myofacial pain, chronic low back pain. The most recent MDS (minimum data set assessment) dated 9/9/13 included, but was not limited to, the following: total cognition score of 15, which indicated cognition was intact; "yes" been on a scheduled pain medication regimen; "yes" had pain frequently; "yes" pain made it hard to sleep, limited day to day activities and had</p>		<p>have their physician's orders and MAR reviewed for discrepancies by the DCS or Nurse Manager weekly times four weeks then monthly for five months. The DCS will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action is indicated.</p> <p>5.) Compliance date: 11/20/2013</p>	

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	<p>an intensity of "10" (on a scale of 1 to 10, with 10 being the most severe pain).</p> <p>A physician order, dated 9/18/13, indicated the following: "Percocet 10-325 mg, 1 tab (tablet) po (by mouth) q (every) 6 hours for breakthrough pain, max (maximum) 3/day." The handwritten order of the medication on the MAR (medication administration record), was undated, and began with documentation of administration of medication on 9/19/13. On 9/21/13, it was documented Resident A received 4 doses of Percocet on 9/21/13. The Controlled Substance Record indicated the resident had Percocet signed out on 9/21/13 at the following times: 12 A.M., 6 A.M., 12 P.M. and 6 P.M.</p> <p>On 9/24/13, an order clarification, was received for the above Percocet order. It indicated "Percocet 10-325 mg, 1 tab (tablet)...3x (times) day prn (as needed) breakthrough pain (6 hours between doses).</p> <p>The current MAR indicated the following dated 9/20/12: "Percocet and Opana ER are to be taken at least 2 hours apart, monitor for sedation." The current MAR indicated</p>			

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	<p>Opana was given at 6 A.M. and 6 P.M. Percocet was documented as administered on the following dates and times: 10/2=7 A.M.; 10/4=7:30 A.M.; 10/7=7:30 A.M.; 10/15=6 P.M.; 10/16=6 P.M.; 10/19=7 A.M.</p> <p>On 10/24/13 at 1:35 P.M., the Regional RN was interviewed. At the time, she provided copies of the following prescriptions dated 10/16/13: Opana ER 10 mg 1 every 12 hours for chronic pain at 3 A.M. and 3 P.M. and Percocet 10-325 mg, 1 tablet every 4-6 hours prn (as needed) pain. The prescriptions had been attached on an order form titled "Prescription order, valid only if faxed to pharmacy designated below." On each of the prescriptions, was a stamp which indicated "valid only if faxed to (name and address of pharmacy), faxed by..." Both of the prescriptions had been initialed in the designated area which indicated they had been faxed.</p> <p>The Regional RN indicated the actual prescriptions were not kept on the chart as she didn't feel comfortable with this. She indicated the actual prescriptions were kept in an office. She indicated the nurse used these prescriptions to write the order from. Documentation was lacking on the</p>			

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	<p>current clinical record of an order for the medications Opana and Percocet dated 10/16/13.</p> <p>The October 2013 MAR indicated the following: "Opana ER 10 mg every 12 hours at 6 A.M. and 6 P.M. for chronic pain, max 2/day." "Percocet 10-325 mg, give 1 tablet orally every 6 hours for breakthrough pain, max 3/day." Handwritten beneath the column of "Hour" was prn (as needed).</p> <p>Documentation was lacking in the current clinical record to include current medication orders.</p> <p>On 10/28/13 at 4:20 P.M. the Administrator provided a copy of the "Direct Care Staff Annual Survey Education", which was from the Plan of Correction binder. This form indicated, but was not limited to, the following; "The DCS (Director of Clinical Services, ADCS (Assistant Director of Clinical Services) and/or licensed nurse will review all MARS (medication administration record) and TARS (treatment administration record) daily to validate medications and treatments were administered...Each licensed staff is responsible to review the MAR and TAR prior to the end of the shift to</p>			

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	<p>validate all medications and treatments were administered...The licensed nurse will compare all handwritten orders for the previous month with the current month MAR or TAR to ensure all MD orders are on the current month MAR/TAR...All care provided must be documented in the appropriate section of the resident medical record...If you don't document the care you provide, it is assumed you did not provide care..."</p> <p>2. Review of the clinical record for Resident #C on 10/24/13 at 9:30 a.m., indicated the following: diagnoses included, but were not limited to, pain, asymptomatic hypotension, nervous breakdown, MDD (Major Depression Disorder) with psychotic features, GERD (gastroesophageal reflux disease), encephalopathy, insomnia, pseudo dementia, anxiety.</p> <p>The Physician's Orders for 9/1/13 to 9/30/13 indicated Hydrocodone-APAP (Norco) 5/325 mg (milligrams) give 1 tablets orally every 8 hours PRN (as needed) for pain. Originally ordered on 4/23/13.</p>						

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	<p>Review of the MARS (Medication Administration Record Sheet) and the Controlled Substances Record for Resident #C, for the month of September 2013, indicated the following discrepancies:</p> <p>-On 9/24/13 the MARS indicated Hydrocodone-APAP 5-325 mg, was given at 4:00 p.m., The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out 4:00 p.m., 11:00 p.m. and 7:00 a.m.. The medication administration times at 4:00 p.m. and 11:00 p.m. indicated the Hydrocodone was given 7 hours apart.</p> <p>-On 9/25/13 MARS did not indicated the time of the administration, only the staff's initials. The Controlled Substances Record for the same dated indicated Hydrocodone-APAP 5-325 mg was signed out at 10:00 a.m., 4:00 p.m., and 10:00 p.m.. The medication times indicated the Hydrocodone was given 6 hours apart.</p> <p>-On 9/26/13 MARS indicated Hydrocodone-APAP 5-325 mg, was given 9:00 a.m., 2:15 p.m., 8:00 p.m. The Controlled Substances Record on the same date indicated</p>			

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	<p>Hydrocodone-APAP 5/325 mg was signed out at 9:00 a.m., 2:15 p.m., 8:00 p.m.. The administration times indicated Hydrocodone-APAP 5-325 mg, was given 5 hours and 15 minutes and 5 hours and 45 minutes between doses consecutively.</p> <p>-On 9/27/13 the MARS indicated Hydrocodone-APAP 5-325 mg, was given at 7:00 a.m. and 11:00 a.m. The medication administration times 7:00 a.m. to 11:00 a.m., indicated Hydrocodone-APAP 5-325 mg, was given 4 hours apart. The Controlled Substances Record for the same date indicated the Hydrocodone-APAP 5-325 mg was signed out at 7:00 a.m., 11:00 a.m., and 5:00 p.m. Review of the administration times from 11:00 a.m. to 5:00 p.m. indicated Hydrocodone-APAP 5-325 mg was given 6 hours apart.</p> <p>-On 9/28/13 the MARS indicated Hydrocodone-APAP 5-325 mg, was given at 3:15 p.m.. The Controlled Substances Record for the same date indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 10:00 a.m., 3:00 p.m., and 3:15 p.m.. The medication administration times 10:00 a.m. to 3:00 p.m. was 5 hours apart and 3:00 p.m. to 3:15 p.m. was 15 minutes apart.</p>			

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	<p>-On 9/29/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was administered 3 times, the first two entries were illegible and the third was given at 3:15 p.m. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg 1 tablet was signed out at 10:45 a.m. and 3:15 p.m.. The medication administration times indicated Hydrocodone-APAP 5-325 mg was given 4 and 1/2 hours apart.</p> <p>-On 9/30/13 the MARS indicated the Hydrocodone-APAP 5-325 mg, was given at 7:30 a.m., 2 p.m. and 8:15 p.m. The Controlled Substances Record indicated Hydrocodone-APAP 5-325 mg, 1 tablet was given at 7:30 a.m., 1:50 p.m. and 8:15 p.m. The medication administration times, 7:30 a.m. to 1:50 p.m. indicated it was given 6 hours and 20 min apart and 1:50 p.m. to 8:15 p.m. indicated it was given 6 hours and 25 minutes apart.</p> <p>Review of the MARS and the Controlled Substances Record for Resident #C, for the month of October 2013, indicated the following discrepancies:</p> <p>-On 10/1/13 the MARS indicated the</p>			

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	<p>Hydrocodone-APAP 5-325 mg, was given at 5:00 p.m. The Controlled Substances Record for the same date indicated the Hydrocodone -APAP 5-325 mg, 1 tablet was signed out at 7:00 a.m., 12:00 p.m. and 5:00 p.m.. The medication administration times, 7:00 a.m. to 12:00 p.m. indicated it was given 5 hours apart and 12:00 p.m. to 5:00 p.m. indicated it was given 5 hours apart.</p> <p>-On 10/3/13 the MARS indicated the Hydrocodone-APAP 5-325 mg, was given at 7:00 a.m.. The Controlled Substances Record for the same date indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 7:05 a.m. and 1:00 p.m. The medication administration times indicated the Hydrocodone-APAP 5-325 mg. was given 6 hours apart.</p> <p>-On 10/4/13 the MARS indicated the Hydrocodone-APAP 5-325 mg, was given at 7:00 a.m. and 11:00 a.m. Review of the administration times indicated the Hydrocodone-APAP 5-325 mg was given 4 hours apart. The Controlled Substances Record indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 7:15 a.m., 1:30 p.m. and 9:45 p.m.. The medication administration times, 7:15 a.m. to 1:30 p.m., indicated the</p>			

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	<p>Hydrocodone-APAP 5-325 mg was given 6 hours 15 minutes apart.</p> <p>-On 10/7/13 the MARS indicated the Hydrocodone-APAP 5-325 mg, was given at 7:00 a.m., 1:00 p.m., 8:00 p.m.. The medication administration times, 7:00 a.m. to 1:00 p.m. was given 6 hours apart and 1:00 p.m. to 8:00 p.m. was given 7 hours apart. The Controlled Substances Record on the same date indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 6:50 a.m., 11:30 a.m. and 8 p.m.</p> <p>-On 10/8/13 the MARS indicated the Hydrocodone-APAP 5-325 mg, was given at 7:00 a.m.. The Controlled Substances Record indicate Hydrocodone-APAP 5-325 mg, 1 tablet at 7:00 a.m., 12:30 p.m., and 8:30 p.m.. The medication administration times 7:00 a.m. to 12:30 p.m. indicated the Hydrocodone-APAP 5-325 mg was given 5 1/2 hours apart.</p> <p>-On 10/11/13 the MARS indicated Hydrocodone-APAP 5-325 mg, was given at 7:00 a.m. and 3:00 p.m.. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 10:00 a.m.</p>			

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	<p>and 3:00 p.m.. The medication administration times 10:00 a.m. to 3:00 p.m., indicated the Hydrocodone-APAP 5-325 mg was given 5 hours apart.</p> <p>-On 10/13/13 the MARS indicated the Hydrocodone-APAP 5-325 mg, was given at 7:00 a.m.. The Controlled Substances Record for the same date, indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 6:00 a.m., 2:00 p.m. and 9:00 p.m.. The administration times, 2:00 p.m. to 9:00 p.m., indicated the medication was given 7 hours apart.</p> <p>On 10/18/13 the MARS indicated the Resident received Hydrocodone-APAP 5-325 mg, at 7:30 a.m. and 3:30 p.m.. The Controlled Substances Record indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 7:30 a.m., 3:00 p.m. and 7:10 p.m.. The administration times 3:00 p.m. to 7:10 p.m., indicated the medication was given 4 1/2 hours apart.</p> <p>A Physician's order on 10/19/13: Hydrocodone-APAP 5-325 mg, give 2 tablets po (orally) q (every) 6 hours PRN (as needed) for moderate to severe pain.</p>			

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	<p>-On 10/19/13 the MARS indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was given at 7:00 a.m. and 3:00 p.m.. The Controlled Substances Record on the same date indicated Hydrocodone-APAP 5/325 mg, 1 tablet was signed out at 8:00 a.m., 3:00 p.m. and 2 tablets at 9:00 p.m.</p> <p>-On 10/22/13 the MARS indicated Hydrocodone-APAP 5-325 mg, 2 tablets were given at 7:30 a.m. and 1:45 p.m., Hydrocodone-APAP 5-325 mg, 1 tablet was given at 3 p.m.. The medication administration times 1:45 p.m. to 3:00 p.m. indicated it was given 1 hour and 15 minutes apart. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 2 tablets were signed out at 7:30 a.m. and 1:45 p.m. and there was not a dose signed out at 3 p.m.</p> <p>Resident #C was interviewed on 10/25/13 at 11:50 a.m. During the interview she indicated she received her pain medication on a timely basis. She also indicated her pain was well controlled.</p> <p>The Medication Regimen Review indicated the Pharmacist reviewed the Resident's medications on 9/9/13</p>						

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	<p>and on 10/21/13, and no irregularities were noted.</p> <p>This deficiency was cited on 8/21/13 and the facility failed to implement the plan to correct the deficiency.</p> <p>3.1-35(g)(2)</p>				

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on interview and record review, the facility failed to ensure the Pharmacist identified discrepancies and inaccuracies in administration</p>	F000431	F 431 Residents B, C, D, & E showed no apparent adverse effect. Residents B, C, D, & E's physicians and Responsible Parties were notified of medication	11/20/2013			

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	<p>and documentation of narcotic medications for 4 residents (Resident D, Resident B, Resident C, and Resident E) reviewed of 10 residents reviewed for receiving narcotic medications.</p> <p>Findings include:</p> <p>1. On 10/25/13 at 10:30 A.M., the clinical record of Resident D was reviewed. The current MAR (medication administration record) for October 2013, indicated the following order dated 9/20/13: Opana ER (extended release) 10 mg, 1 tab (tablet) q (every) 12 hours at 6 A.M. and 6 P.M. for chronic pain. This medication was currently documented as given at 6 A.M. and 6 P.M. Also an order for Percocet 10-325 was dated 9/20/13 and indicated the following: give 1 tablet every 6 hours for breakthrough pain, max (maximum) of 3/day.</p> <p>On 10/24/13 at 1:35 P.M., the Regional RN was interviewed. At the time, she provided copies of the following prescriptions dated 10/16/13: Opana ER 10 mg 1 every 12 hours for chronic pain at 3 A.M. and 3 P.M. and Percocet 10-325 mg, 1 tablet every 4-6 hours prn (as needed) pain. The prescriptions had</p>		<p>administration discrepancies by the DCS on November 15, 2013 and any new orders given to the nurse by the physicians were received, noted, and implemented at that time. In-house residents will have their current physician's orders and medication administration records (MAR) reviewed by a member of the IDT to identify and address discrepancies by November 18, 2013. The RDCS re-educated the Department Heads on the regulation for F431 on 11/12/2013. The RDCS will re-educate the Pharmacist consultant on the regulation by 11/20/2013. The DCS or designee will re-educate the staff nurses on documentation of narcotics by November 20, 2013. The DCS or designee will review the documentation of ten residents receiving narcotic pain medications for discrepancies or inaccuracies weekly times four weeks then monthly for five months. The DCS will report the review findings to the QAPI committee for two quarterly QAPI meetings. The QAPI committee will determine if further action is indicated.</p> <p>Compliance date: 11/20/2013</p>				

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	<p>been attached on an order form titled "Prescription order, valid only if faxed to pharmacy designated below." On each of the prescriptions, was a stamp which indicated "valid only if faxed to (name and address of pharmacy), faxed by..." Both of the prescriptions had been initialed in the designated area, which indicated they had been faxed.</p> <p>The Regional RN indicated the actual prescriptions were not kept on the chart as she didn't feel comfortable with this. She indicated the actual prescriptions were kept in an office. She indicated the nurse used these prescriptions to write the order from. Documentation was lacking on the current clinical record of an order for the medications Opana and Percocet dated 10/16/13.</p> <p>Nurses notes (NN) dated 10/16/13, indicated the following: "Res (resident) returned from appt (appointment) with (name of pain center)...returned with new scripts (prescriptions) for Opana...Percocet...Pharmacy faxed..."</p> <p>Documentation was lacking in the current MAR of the most recent physician order for Percocet with the</p>						

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	<p>frequency changed to every 4-6 hours prn (as needed) as well as documentation of the most recent prescriptions for medications included, but not limited to, Percocet and Opana.</p> <p>On 10/28/13 at 9:30 A.M. the DCS (Director of Clinical Services) was interviewed regarding the September 2013 MAR (medication administration record) for Resident D. She indicated when a prn (as needed) pain medication was given, the result of the medication administration should be documented on the pain flow sheet as well as the front and back of the MAR. At the time, the DCS reviewed the MAR for September 2013 and indicated she was unable to read some of the times the Percocet had been documented and indicated initials of the nurses were missing from the times administered. For the time period of September 21 to the 30th the following discrepancies were noted with the prn Percocet: (opioid analgesic):</p> <p>On 9/21, 9/22, 9/23 and 9/24/13: documentation was lacking on the pain flow sheet of any Percocet administration (date/time/site/location of pain, type, current intensity, non-verbal indicators, precipitating</p>			

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	<p>aggravating factors, non-med intervention, medication/dose, initials, after intervention and side effects) . Documentation was lacking on the front and back of the MAR of times the Percocet had been administered. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>On 9/27/13, it was documented on the MAR the resident received Percocet at 7 A.M., 12 P.M. and 6 P.M. Documentation was lacking on the 6 P.M. entry of initials of the nurse who administered the medication; the pain flow sheet had one entry for the date and was documented at 7 A.M. On the controlled substance record for 9/27/13, the Percocet had been signed out at 6 A.M., 12 P.M. and 6 P.M. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>On 9/28/13, the MAR appeared to have two documented entries for Percocet administration, first time was illegible and the second time was documented as 7 P.M. Documentation was lacking on the Pain Flow Sheet of any medication administration for the date and the Controlled Substance Record</p>			

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	<p>indicated Percocet had been given at 7:30 A.M., 1:30 P.M. and 7:30 P.M. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>On 9/30/13, the MAR indicated the resident had two doses of Percocet administered. Documentation was lacking on the Pain Flow Sheet of any Percocet administered on 9/30/13. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>The September 2013 Controlled Substance Record for Resident D, indicated on 9/25/13, there were 3 pills of Percocet signed out at the following times: 6 A.M., 12 P.M. and 6 P.M. The September 2013 MAR (medication administration record) indicated on 9/25/13, two doses Percocet were administered. No time is documented on the MAR as to when the Percocet was administered. Documentation was lacking on the back of the MAR regarding the pain medication administered and/or follow up. Documentation on the Pain flow Sheet indicated on 9/25/13, the medication was given 3 times.</p> <p>A physician order for Resident D, dated 9/18/13, indicated the following:</p>						

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	<p>"Percocet 10-325 mg, 1 tab (tablet) po (by mouth) q (every) 6 hours for breakthrough pain, max (maximum) 3/day." The handwritten order of the medication on the MAR (medication administration record), was undated, and began with documentation of administration of medication on 9/19/13. On 9/21/13, it was documented Resident A received 4 doses of Percocet on 9/21/13. The Controlled Substance Record indicated the resident had Percocet signed out on 9/21/13 at the following times: 12 A.M., 6 A.M., 12 P.M. and 6 P.M.</p> <p>On 9/24/13, an order clarification, was received for the above Percocet order. It indicated "Percocet 10-325 mg, 1 tab (tablet)...3x (times) day prn (as needed) breakthrough pain (6 hours between doses).</p> <p>The current MAR for Resident D indicated the following dated 9/20/12: "Percocet and Opana ER are to be taken at least 2 hours apart, monitor for sedation." The current MAR indicated Opana was given at 6 A.M. and 6 P.M. Percocet was documented as administered on the following dates and times: 10/2=7 A.M.; 10/4=7:30 A.M.; 10/7=7:30 A.M.; 10/15=6 P.M.; 10/16=6 P.M.;</p>						

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	<p>10/19=7 A.M.</p> <p>On 10/28/13 at 11:20 A.M., the Pharmacist Consultant was interviewed. She indicated she was at the facility on 10/21/13. She indicated she leaves a report at the facility which included her findings for that visit. She indicated for her monthly visits, she reviewed the following: looked at the chart, reviewed the new MAR (printed by the Pharmacy) to make sure orders were reflected on the new MAR, and reviewed labs and orders since the last pharmacy visit. She indicated she looks at a sample (percentage) of charts in detail on her monthly visits. She indicated it is a random sample and she was unaware of the charts she reviewed in detail on her last visit.</p> <p>On 10/28/13 at 2:20 P.M. a current copy of the "Required Consultant Services" was received from the Administrator. This information included, but was not limited to, the following: "Consultant Services Relating to Provisions of Pharmacy Products and Services...Consultant will assist Facility in providing timely and appropriate Pharmacy Products and Services that support resident's healthcare needs, that are consistent with current standards of practice and</p>				

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	<p>that meet state and federal requirements...consultant will collaborate with Facility...to...develop mechanisms for communicating, addressing and resolving issues related to pharmacy products and services...Consultant will determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled...Consultant will encourage Facility to act upon a report of clinically significant risks or existing adverse consequences or other irregularities.</p> <p>2. Review of the clinical record for Resident #B on 10/24/13 at 1:33 p.m., indicated the following: diagnoses included, but were not limited to, abdominal pain and chronic back pain.</p> <p>A physician's order for Resident #B, dated 9/24/13, indicated Hydromorphone (Dilaudid) 4 mg (milligrams) give 1 tab orally every four hours as needed, maximum of 4 per day.</p> <p>Review of the Medication Record and Controlled Substances Record for Resident #B, for the month of September, 2013, indicated the</p>			

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	<p>following discrepancies:</p> <ul style="list-style-type: none"> <li>- On 9/20/13 the Medication Record did not indicate Hydromorphone was given at any time during a 24 hour period. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 a.m. and 4:00 p.m.</li> <li>- On 9/21/13 the Medication Record did not indicate Hydromorphone was given at any time during a 24 hour period. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 a.m. and 9:00 p.m.</li> <li>- On 9/22/13 the Medication Record did not indicate Hydromorphone was given at any time during a 24 hour period. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out by staff at 3:45 p.m. and 10:00 p.m.</li> <li>- On 9/24/13 the Medication Record did not indicate Hydromorphone was given at any time during a 24 hour period. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 a.m.</li> <li>- On 9/25/13 the Medication Record</li> </ul>			

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	<p>did not indicate Hydromorphone was given at any time during a 24 hour period. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 p.m.</p> <p>- On 9/26/13 at 8:00 p.m., the Medication Record did not indicate Hydromorphone was given. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 p.m.</p> <p>Review of the Medication Record and the Controlled Substances Record for Resident #B, for the month of October, 2013, indicated the following discrepancies:</p> <p>- On 10/1/13 at 6:45 p.m., the Medication Record did not indicate Hydromorphone was given. The Controlled Substances Report for the same date indicated Hydromorphone 4 mg was signed out by staff at 6:45 p.m.</p> <p>- On 10/3/13 at 3:00 p.m., the Medication Record did not indicate Hydromorphone was given. The Controlled Substances Report for the same date indicated Hydromorphone</p>			

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	<p>4 mg was signed out by staff at 3:00 p.m.</p> <p>- On 10/10/13 at 8:00 a.m., the Medication Record did not indicate Hydromorphone was given. The Controlled Substances Report for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 a.m.</p> <p>- On 10/18/13 at 8:02 p.m. the Medication Record did not indicate the Hydromorphone was given. The Controlled Substances Report for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:02 p.m.</p> <p>- On 10/21/13 at 8:00 p.m., the Medication Record did not indicate the Hydromorphone was given. The Controlled Substances Report for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 p.m.</p> <p>- On 10/23/13 at 12:30 p.m., the Medication Record did not indicate the Hydromorphone was given. The Controlled Substances Report for the same date indicated Hydromorphone 4 mg was signed out by staff at 12:30 p.m.</p>						

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	<p>The Medication Regimen Review for Resident #B, dated 10/21/13 and completed by the Consultant Pharmacist, indicated no irregularities were noted.</p> <p>3. Review of the clinical record for Resident #C on 10/24/13 at 9:30 a.m., indicated the following: diagnoses included, but were not limited to, pain, asymptomatic hypotension, nervous breakdown, MDD (Major Depression Disorder) with psychotic features, GERD (gastroesophageal reflux disease), encephalopathy, insomnia, pseudo dementia, anxiety.</p> <p>The Physician's Orders for 9/1/13 to 9/30/13 indicated Hydrocodone-APAP (Norco) 5/325 mg (milligrams), give 1 tablets orally every 8 hours PRN (as needed) for pain. The physician originally order was dated on 4/23/13.</p> <p>Review of the MARS (Medication Administration Record Sheet) and the Controlled Substances Record for Resident #C, for the month of September, 2013, indicated the following discrepancies:</p> <p>- On 9/20/13 the MARS did not indicate Hydrocodone-APAP 5-325</p>				

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	<p>mg was given. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg 1 tablet was signed out by staff at 9:30 a.m. and 8:00 p.m.</p> <p>- On 9/21/13 the MARS did not indicate Hydrocodone-APAP 5-325 mg was given. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tab was signed out by the staff at 8:00 p.m..</p> <p>- On 9/22/13 the MARS did not indicate Hydrocodone-APAP 5-325 mg was given. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out by the staff at 9 a.m..</p> <p>-On 9/23/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 3:45 p.m. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 8:00 a.m. and 3:45 p.m..</p> <p>-On 9/24/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 4:00 p.m., The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325</p>			

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	<p>mg, 1 tablet was signed out 4:00 p.m., 11:00 p.m. and 7:00 a.m.</p> <p>-On 9/25/13 the MARS did not indicate a time for the administration of Hydrocodone-APAP 5-325 mg, only the staff's initials appeared. The Controlled Substances Record for the same dated indicated Hydrocodone-APAP 5-325 mg was signed out at 10:00 a.m., 4:00 p.m., and 10:00 p.m.</p> <p>-On 9/27/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 7:00 a.m. and 11:00 a.m. The Controlled Substances Record for the same date indicated the Hydrocodone-APAP 5-325 mg was signed out at 7:00 a.m., 11:00 a.m., and 5:00 p.m.</p> <p>-On 9/28/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 3:15 p.m.. The Controlled Substances Record for the same date indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 10:00 a.m., 3:00 p.m., and 3:15 p.m.</p> <p>-On 9/29/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was administered 3 times, the first two entries were illegible and the third was given at 3:15 p.m. The</p>			

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	<p>Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg 1 tablet was signed out at 10:45 a.m. and 3:15 p.m..</p> <p>Review of the MARS (Medication Administration Record Sheet) and the Controlled Substances Record for Resident #C, for the month of October 2013, indicated the following discrepancies:</p> <p>-On 10/1/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 5:00 p.m. The Controlled Substances Record for the same date indicated the Hydrocodone -APAP 5-325 mg, 1 tablet was signed out at 7:00 a.m., 12:00 p.m. and 5:00 p.m.</p> <p>-On 10/3/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m.. The Controlled Substances Record for the same date indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 7:05 a.m. and 1:00 p.m..</p> <p>-On 10/4/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m. and 11:00 a.m.. The Controlled Substances Record indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at</p>			

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	<p>7:15 a.m., 1:30 p.m. and 9:45 p.m.</p> <p>-On 10/7/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m., 1:00 p.m., 8:00 p.m.. The Controlled Substances Record on the same date indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 6:50 a.m., 11:30 a.m. and 8 p.m.</p> <p>-On 10/8/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m.. The Controlled Substances Record indicate Hydrocodone-APAP 5-325 mg, 1 tablet at 7:00 a.m., 12:30 p.m., and 8:30 p.m.</p> <p>-On 10/11/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 7:00 a.m. and 3:00 p.m.. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 10:00 a.m. and 3:00 p.m.</p> <p>-On 10/12/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m.. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 7 a.m. and "Pp" [sic], an illegible time. Could</p>			

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	<p>not determine the time the medication was signed out.</p> <p>-On 10/13/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m.. The Controlled Substances Record for the same date, indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 6 a.m., 2:00 p.m. and 9:00 p.m..</p> <p>-On 10/14/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 6 a.m.. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 6:00 a.m. and 8:00 p.m.</p> <p>-On 10/16/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m. and the Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg was signed out at 7:30 a.m., 3:00 p.m. and 10:05 p.m..</p> <p>-On 10/17/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 8:00 a.m. and 7:00 p.m.. The Controlled Substances Record indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 8 a.m. and 3:25 p.m.</p>			

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	<p>On 10/18/13 the MARS indicated the Resident received Hydrocodone-APAP 5-325 mg at 7:30 a.m. and 3:30 p.m.. The Controlled Substances Record indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 7:30 a.m., 3 p.m. and 7:10 p.m..</p> <p>A Physician's order on 10/19/13: indicated Hydrocodone-APAP 5-325 mg, give 2 tablets po (orally) q (every) 6 hours PRN (as needed) for moderate to severe pain.</p> <p>The Nurses Progress Note dated 10/19/13 at 5:30 p.m. indicated, "...Resident has been complaining of increased pain and current PRN pain med (medication) not effective. Dr. notified. N.O.'s (New Order) were obtained at 10 a.m. for Hydrocodone-APAP 5/325 give 2 tabs po q 6 hr prn moderate - severe pain. Res notified at that time."</p> <p>-On 10/19/13 the MARS indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was given at 7:00 a.m. and 3:00 p.m.. The Controlled Substances Record on the same date indicated Hydrocodone-APAP 5/325 mg, 1 tablet was signed out at 8:00 a.m., 3:00 p.m. and 2 tablets at 9:00 p.m.</p>						

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	<p>-On 10/20/13 the MARS indicated Hydrocodone-APAP 5-325 mg, 2 tablets were given at 8:00 a.m. and Hydrocodone-APAP 5-325 mg, 1 tablet was given at 3:00 p.m.. The Controlled Substances Record on the same date indicated Hydrocodone-APAP 5/325, 2 tablets were signed out at 7:00 a.m. and 3:00 p.m..</p> <p>-On 10/21/13 the MARS indicated Hydrocodone-APAP 5-325 mg, 2 tablets were given at 7:30 a.m. and Hydrocodone-APAP 5-325 mg, 1 tablet was given at 3:00 p.m.. The Controlled Substances Record on the same date indicated Hydrocodone-APAP 5/325 2 tabs were signed out at 7:30 a.m. and 3:00 p.m..</p> <p>-On 10/22/13 the MARS indicated Hydrocodone-APAP 5-325 mg, 2 tablets were given at 7:30 a.m. and 1:45 p.m., Hydrocodone-APAP 5-325 mg, 1 tablet was given at 3:00 p.m.. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 2 tablets were signed out at 7:30 a.m. and 1:45 p.m. and there was not a dose signed out at 3:00 p.m.</p>				

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	<p>-On 10/23/13 the MARS indicated Hydrocodone-APAP 5-325 mg, 2 tablets were given at 7:15 a.m. and Hydrocodone-APAP 5-325 mg, 1 tablet was given at 3:30 p.m.. The Controlled Substances Record on the same date indicate Hydrocodone-APAP 5-325 mg, 2 tablets were signed out at 7:15 a.m. There was not a dose of Hydrocodone-APAP 5-325 mg signed out at 3:30 p.m. on 10/23/13.</p> <p>- On 10/24/13 The MARS indicated no Hydrocodone was given. The Controlled Substances Record on the same date indicated Hydrocodone-APAP 5-325 mg, 2 tablets were signed out at 3:25 p.m., 2 tabs at 7:15 a.m. and 3:30 p.m.</p> <p>Review of the Medication Regimen Review for Resident # C indicated the Pharmacist reviewed Resident's #C medications on 9/9/13 and on 10/21/13, and no irregularities were noted.</p> <p>4. The record review for Resident #E began 10-24-2013 at 3:28 p.m. Diagnoses included but were not limited to :arteriosclerotic cardiovascular disease, morbid obesity, chronic kidney disease,</p>			

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	<p>tracheostomy, gastrostomy, diabetes, chronic depression, peripheral vascular disease, osteoarthritis of the knees, aphasia, history of multiple cerebral vascular accidents, hypertension, recurrent bronchopneumonia, obstructive sleep apnea, right hemiplegia and hypertensive cardiovascular disease.</p> <p>The MDS (Minimum Data Set) significant change assessment done on 8-5-2013 for Resident #E indicated a BIMS (Brief Interview of Mental Status assessment that measures cognitive level) score of "rarely/never is understood".</p> <p>A review of the physician's recapitulation for September 2013 and October 2013 indicated Resident #E had PRN (as needed) narcotic pain medication ordered as followed: "Hydrocodone - APAP 5-325 mg (Norco) give 1 tablet orally every 8 hours as needed for pain".</p> <p>A review of the Medication Administration Record (MAR), the Pain Flow Sheet, the Controlled Substances Record and the Nurse's Medication Notes for Resident #E, from September 20, 2013 and forward indicated the following discrepancies for Resident #E's</p>			

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	<p><b>hydrocodone:</b></p> <p>On 9-20-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances Record indicated the hydrocodone was signed out at 2:30 a.m. and 4:00 p.m.</p> <p>On 9-21-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances Record indicated the hydrocodone was signed out at 8:00 a.m. and 3:00 p.m.</p> <p>On 9-22-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances record indicated hydrocodone was signed out at 12:00 a.m.</p> <p>On 9-23-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances record indicated hydrocodone was signed out at 12:15 a.m. and 10:00 (a.m. or p.m. was not indicated).</p> <p>On 9-24-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances Record</p>				

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	<p>indicated hydrocodone was signed out at 8:00 a.m. and 5:00 p.m.</p> <p>On 9-25-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 2:00 a.m. and 4:00 p.m.</p> <p>On 9-26-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 6:00 a.m. and 12:00 (a.m. or p.m. not legible).</p> <p>On 9-27-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 8:00 a.m. and 4:00 p.m.</p> <p>On 9-28-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 6:00 a.m.</p> <p>On 9-29-2013, the MAR lacked documentation to indicate hydrocodone was administered and</p>			

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	<p>the Controlled Substances Record indicated hydrocodone was signed out at 6:00 a.m. and 1:30 p.m.</p> <p>On 10-4-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 9:40 p.m.</p> <p>On 10-7-2013, the MAR indicated hydrocodone was administered at 7:30 a.m. and 4:00 p.m. and the Controlled Substances Record indicated hydrocodone was signed out at 7:00 a.m. only.</p> <p>On 10-11-2013, the MAR indicated hydrocodone was administered at 10:00 a.m. and the Controlled Substances Record indicated hydrocodone was signed out at 10:00 a.m. and 9:15 p.m.</p> <p>On 10-12-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substances records indicated hydrocodone was signed out at 6:00 a.m.</p> <p>On 10-13-2013, the MAR lacked documentation to indicate hydrocodone was administered and</p>						

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	<p>the Controlled Substance records indicated hydrocodone was signed out at 12:00 a.m.</p> <p>On 10-14-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substance Notes indicated hydrocodone was signed out at 12:00 a.m. and 6:00 a.m.</p> <p>On 10-15-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substance Notes indicated hydrocodone was signed out at 1:00 a.m.</p> <p>On 10-22-2013, the MAR indicated hydrocodone was administered at 4:00 a.m. and the Controlled Substance Notes did not indicate hydrocodone was signed out on 10-22-2013.</p> <p>On 10-23-2013, the MAR lacked documentation to indicate hydrocodone was administered and the Controlled Substance Notes indicated hydrocodone was signed out at 4:00 a.m.</p> <p>On 10-24-2013, the MAR lacked documentation to indicate hydrocodone was administered and</p>			

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	<p>the Controlled Substance Notes indicated hydrocodone was signed out at 11:00 p.m. and 7:00 a.m.</p> <p>During an interview with LPN #2 on 10-28-2013 at 1:21 p.m., the LPN indicated the administration of hydrocodone for Resident #E should be documented in the narcotic book (Controlled Substance Record), the MAR and the Pain Flow Sheet. The LPN indicated she did not consistently document the administration of the hydrocodone on the Pain Flow Sheet.</p> <p>During an interview with the Interim Director of Clinical Services (DCS) on 10-28-2013 at 1:24 p.m., the DCS indicated she was aware the nursing staff was not consistently documenting the pain medication use on all of the required documentation forms for pain and for the nebulizer treatments. The DCS indicated the facility did not have a policy regarding the documentation, but had a plan. The DCS indicated staff was instructed on the plan for documentation expectations last week as followed: "...all documentation is to be completed timely: i.e. prn documented at time of administration - to be signed out on MAR, back of MAR, Pain Flow Sheet,</p>						

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	<p>Narcotic Control Record, etc., assessments to be documented on MAR, Respiratory Flow Sheet, Nurses' Note...."</p> <p>During an interview with LPN #3 on 10-28-2013 at 1:30 p.m., the LPN indicated the documentation for PRN pain medications should be done on the narcotic count sheet (Controlled Substance Record), the MAR--front and back, the Pain Flow Sheet, the 24 hour report and in the nurse's notes. For routine pain meds, the LPN indicated documentation would be on the MAR and on the narcotic count sheet (Controlled Substance Record).</p> <p>A review of the Medication Regimen Review for Resident #E indicated the pharmacist reviewed Resident #E's medications on 10-21-2013. No discrepancies or inaccuracies were noted.</p> <p>This deficiency was cited on 8/21/13 and the facility failed to implement the plan to correct the deficiency.</p> <p>3.1-25(i)</p>			

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F000514 SS=E	<p>483.75(I)(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 interview and record review, the facility failed to maintain complete documentation of pain medications for 4 residents (Resident #D, Resident #B, Resident #C, and Resident #E) who were reviewed for pain medications. The facility also failed to ensure accurate documentation for nebulizer treatment administration, including the before and after respiratory assessment, was completed for 1 of 1 resident reviewed for respiratory treatments (Resident #F). The facility further failed to ensure the correct photographs of 2 residents (Resident #G and Resident #H) were placed under the divider tab for their correct room in the Treatment Administration Record.</p>	F000514	<p>F514 1. Residents B, C, D, E &amp; F showed no apparent adverseeffect. The correct photograph has beenplaced under the correct divider tab in the Treatment Administration Record(TAR) for Resident G. The correctphotograph has been placed under the correct divider tab in the TAR forResident H. Residents G and H sufferedno harm. In-house residents willhave their current physician's orders and medication administrationrecords (MAR) reviewed by a member of the IDT to identify and addressdiscrepancies by November 18, 2013. The RDCS re-educated theDepartment Heads on the regulation F514 on 11/12/2013. In-house residents will have theircurrent physician's orders, MAR and TAR reviewed by a member of the IDT to identify</p>	11/20/2013			

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	<p>Findings include:</p> <p>1. On 10/24/13 at 3 P.M., the clinical record of Resident D was reviewed. Diagnoses included, but were not limited to, the following: Muscle spasm, Degenerative Joint Disease, nerve pain, Diabetes, Myofacial pain, chronic low back pain. The most recent MDS (minimum data set assessment) dated 9/9/13 included, but was not limited to, the following: total cognition score of 15, which indicated cognition was intact; "yes" been on a scheduled pain medication regimen; "yes" had pain frequently; "yes" pain made it hard to sleep, limited day to day activities and had an intensity of "10" (on a scale of 1 to 10, with 10 being the most severe pain).</p> <p>On 10/25/13 at 10:30 A.M., the clinical record of Resident D was reviewed. The current MAR (medication administration record) for October 2013, indicated the following order dated 9/20/13: Opana ER (extended release) 10 mg, 1 tab (tablet) q (every) 12 hours at 6 A.M. and 6 P.M. for chronic pain. This medication was currently documented as given at 6 A.M. and 6 P.M. Also an order for Percocet 10-325 was dated 9/20/13 and indicated the</p>		<p>and address discrepancies by November 18, 2013. The DCS or designee will re-educate the staff nurses on pain medication and nebulizer treatment administration documentation by November 20, 2013. Ten residents will have their physician's orders, MAR and TAR reviewed for discrepancies by the DCS or designee weekly times four weeks then monthly for five months. The DCS will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action is indicated. Compliance date: 11/20/2013</p>				

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	<p>following: give 1 tablet every 6 hours for breakthrough pain, max (maximum) of 3/day.</p> <p>On 10/24/13 at 1:35 P.M., the Regional RN was interviewed. At the time, she provided copies of the following prescriptions dated 10/16/13: Opana ER 10 mg 1 every 12 hours for chronic pain at 3 A.M. and 3 P.M. and Percocet 10-325 mg, 1 tablet every 4-6 hours prn (as needed) pain. The prescriptions had been attached on an order form titled "Prescription order, valid only if faxed to pharmacy designated below." On each of the prescriptions, was a stamp which indicated "valid only if faxed to (name and address of pharmacy), faxed by..." Both of the prescriptions had been initialed in the designated area, which indicated they had been faxed.</p> <p>The Regional RN indicated the actual prescriptions were not kept on the chart as she didn't feel comfortable with this. She indicated the actual prescriptions were kept in an office. She indicated the nurse used these prescriptions to write the order from. Documentation was lacking on the current clinical record of an order for the medications Opana and Percocet dated 10/16/13.</p>			

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	<p>Nurses notes (NN) dated 10/16/13, indicated the following: "Res (resident) returned from appt (appointment) with (name of pain center)...returned with new scripts (prescriptions) for Opana...Percocet...Pharmacy faxed..."</p> <p>Documentation was lacking in the current MAR of the most recent physician order for Percocet with the frequency changed to every 4-6 hours prn (as needed) as well as documentation of the most recent prescriptions for medications included, but not limited to, Percocet and Opana.</p> <p>On 10/28/13 at 9:30 A.M. the DCS (Director of Clinical Services) was interviewed regarding the September 2013 MAR (medication administration record) for Resident D. She indicated when a prn (as needed) pain medication was given, the result of the medication administration should be documented on the pain flow sheet as well as the front and back of the MAR. At the time, the DCS reviewed the MAR for September 2013 and indicated she was unable to read some of the times the Percocet had been documented and indicated</p>						

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	<p>initials of the nurses were missing from the times administered. For the time period of September 21 to the 30th the following discrepancies were noted with the prn Percocet: (opioid analgesic):</p> <p>On 9/21, 9/22, 9/23 and 9/24/13: documentation was lacking on the pain flow sheet of any Percocet administration (date/time/site/location of pain, type, current intensity, non-verbal indicators, precipitating aggravating factors, non-med intervention, medication/dose, initials, after intervention and side effects) . Documentation was lacking on the front and back of the MAR of times the Percocet had been administered. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>On 9/27/13, it was documented on the MAR the resident received Percocet at 7 A.M., 12 P.M. and 6 P.M. Documentation was lacking on the 6 P.M. entry of initials of the nurse who administered the medication; the pain flow sheet had one entry for the date and was documented at 7 A.M. On the controlled substance record for 9/27/13, the Percocet had been signed out at 6 A.M., 12 P.M. and 6 P.M. Documentation was lacking in</p>			

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	<p>the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>On 9/28/13, the MAR appeared to have two documented entries for Percocet administration, first time was illegible and the second time was documented as 7 P.M. Documentation was lacking on the Pain Flow Sheet of any medication administration for the date and the Controlled Substance Record indicated Percocet had been given at 7:30 A.M., 1:30 P.M. and 7:30 P.M. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>On 9/30/13, the MAR indicated the resident had two doses of Percocet administered. Documentation was lacking on the Pain Flow Sheet of any Percocet administered on 9/30/13. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>The September 2013 Controlled Substance Record, indicated on 9/25/13, there were 3 pills of Percocet signed out at the following times: 6 A.M., 12 P.M. and 6 P.M. The September 2013 MAR (medication administration record) indicated on</p>			

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	<p>9/25/13, two doses Percocet were administered. No time is documented on the MAR as to when the Percocet was administered. Documentation was lacking on the back of the MAR regarding the pain medication administered and/or follow up. Documentation on the Pain flow Sheet indicated on 9/25/13, the medication was given 3 times.</p> <p>On 10/28/13 at 4:20 P.M. the Administrator provided a copy of the "Direct Care Staff Annual Survey Education", which was from the Plan of Correction binder. This form indicated, but was not limited to, the following; "The DCS (Director of Clinical Services, ADCS (Assistant Director of Clinical Services) and/or licensed nurse will review all MARS (medication administration record) and TARS (treatment administration record) daily to validate medications and treatments were administered...Each licensed staff is responsible to review the MAR and TAR prior to the end of the shift to validate all medications and treatments were administered...The licensed nurse will compare all handwritten orders for the previous month with the current month MAR or TAR to ensure all MD orders are on the current month MAR/TAR...All care</p>				

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	<p>provided must be documented in the appropriate section of the resident medical record...If you don't document the care you provide, it is assumed you did not provide care..."</p> <p>2. Review of the clinical record for Resident #B on 10/24/13 at 1:33 p.m., indicated the following: diagnoses included, but were not limited to, abdominal pain and chronic back pain.</p> <p>A physician's order for Resident #B, dated 9/24/13, indicated Hydromorphone (Dilaudid) 4 mg (milligrams) give 1 tab orally every four hours as needed, maximum of 4 per day.</p> <p>Review of the Medication Record, the Pain Flow Sheet, the Nurse's Medication Notes, and the Controlled Substances Record for Resident #B, for the month of September, 2013, indicated the following discrepancies:</p> <p>- On 9/20/13 the Medication Record did not indicate Hydromorphone was given at any time during a 24 hour period. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out</p>			

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	<p>by staff at 8:00 a.m. and 4:00 p.m.</p> <p>- On 9/21/13 the Medication Record did not indicate Hydromorphone was given at any time during a 24 hour period. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 a.m. and 9:00 p.m.</p> <p>- On 9/22/13 the Medication Record did not indicate Hydromorphone was given at any time during a 24 hour period. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out by staff at 3:45 p.m. and 10:00 p.m.</p> <p>- On 9/23/13 at 5:00 p.m., the Pain Flow Sheet indicated a pain intensity of 8 out of 10 and Dilaudid 4 mg was given. The Medication Record and the Nurse's Medication Notes on that date indicated Hydromorphone 4 mg was given at 8:00 a.m. and 5:00 p.m. The Pain Flow Sheet did not indicate her pain was assessed at 8:00 a.m.</p> <p>- On 9/24/13 the Medication Record did not indicate Hydromorphone was given at any time during a 24 hour period. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 a.m.</p>			

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	<p>- On 9/25/13 the Medication Record did not indicate Hydromorphone was given at any time during a 24 hour period. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 p.m.</p> <p>- On 9/26/13 at 8:00 a.m., the Pain Flow Sheet indicated a pain intensity of 9 out of 10 and Dilaudid 4 mg was given. The Medication Record on that date indicated the Hydromorphone 4 mg was given at 8:00 a.m. and 12:00 p.m., and was documented on the Nurse's Medication Notes. The Pain Flow Sheet did not indicate her pain was assessed at 12:00 p.m. The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was also signed out by staff at 8:00 p.m., but the Medication Record did not indicate it was given.</p> <p>- On 9/27/13 at 5:00 p.m., the Pain Flow Sheet indicated a pain intensity of 7 out of 10 and Hydromorphone 4 mg was given. The Medication Record on that date indicated the Hydromorphone 4 mg was given at 8:00 a.m., 12:00 p.m., and 5:00 p.m., and was documented on the Nurse's Medication Notes. The Pain Flow Sheet did not indicate her pain was</p>			

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	<p>assessed at 8:00 a.m. and 12:00 p.m.</p> <p>- On 9/28/13 the Pain Flow Sheet did not indicate her pain was assessed or any medication was provided on that date. The Medication Record on that date indicated the Hydromorphone 4 mg was given at 8:00 a.m. and 12:00 p.m., and was documented on the Nurse's Medication Notes.</p> <p>Review of the Medication Record, the Pain Flow Sheet, the Nurse's Medication Notes, and the Controlled Substances Record for Resident #B, for the month of October, 2013, indicated the following discrepancies:</p> <p>- On 10/1/13 at 12:00 p.m., the Pain Flow Sheet indicated a pain intensity of 8 out of 10 and Hydromorphone 4 mg was given. The Medication Record on that date indicated the Hydromorphone 4 mg was given at 12:00 p.m. The Nurse's Medication Notes did not indicate the Hydromorphone was given. The Controlled Substances Report for the same date indicated Hydromorphone 4 mg was also signed out by staff at 6:45 p.m., but the Medication Record did not indicate it was given.</p> <p>- On 10/2/13 at 8:00 a.m. and 12:00 p.m., the Medication Record and the</p>			

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	<p>Nurse's Medication Notes indicated Hydromorphone 4 mg was given. The Pain Flow Sheet for that date did not indicate her pain was assessed at 8:00 a.m. and 12:00 p.m.</p> <p>- On 10/3/13 at 8:00 a.m., the Pain Flow Sheet indicated a pain intensity of 8 out of 10 and Dilaudid 4 mg was given. The Medication Record on that date indicated the Hydromorphone 4 mg was given at 8:00 a.m. The Nurse's Medication Notes did not indicate the Hydromorphone was given. The Controlled Substances Report on the same date indicated Hydromorphone 4 mg was also signed out by staff at 3:00 p.m., but the Medication Record did not indicate it was given.</p> <p>- On 10/4/13 at 8:00 a.m., the Medication Record and the Nurse's Medication Notes indicated Hydromorphone 4 mg was given. The Pain Flow Sheet did not indicate her pain was assessed at 8:00 a.m.</p> <p>- On 10/5/13 the Pain Flow Sheet indicated a pain intensity of 9 out of 10 at 8:00 a.m., 10 out of 10 at 2:00 p.m., and 8 out of 10 at 8:00 p.m. The Medication Record indicated Hydromorphone 4 mg was given at those times. The Nurse's Medication</p>			

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	<p>Notes did not indicate the Hydromorphone given.</p> <p>- On 10/6/13 the Pain Flow Sheet indicated a pain intensity of 8 out of 10 at 7:00 a.m. and 8 out of 10 at 5:10 p.m. The Medication Record indicated Hydromorphone 4 mg was given at those times. The Nurse's Medication Notes did not indicate the Hydromorphone was given.</p> <p>- On 10/7/13 at 4:30 p.m., the Pain Flow Sheet indicated a pain intensity of 8 out of 10 and Hydromorphone was given. The Medication Record indicated Hydromorphone 4 mg was given at 8:10 a.m. and 4:30 p.m. The Nurse's Medication Notes indicated Hydromorphone 4 mg was given at 4:30 p.m. The Pain Flow Sheet did not indicate her pain was assessed at 8:10 a.m. The Nurse's Medication Notes did not indicate Hydromorphone 4 mg was given.</p> <p>- On 10/8/13 at 5:30 p.m., indicated a pain intensity of 8 out of 10 with Hydromorphone 4 mg was given. The Medication Record and the Nurse's Medication Notes indicated Hydromorphone 4 mg was given at 7:25 a.m. and 4:30 p.m. The Pain Flow Sheet did not indicate her pain was assessed at 7:25 a.m.</p>						

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	<p>- On 10/9/13 at 7:45 a.m., the Medication Record indicated Hydromorphone 4 mg was given. The Pain Flow Sheet did not indicate her pain was assessed and the Nurse's Medication Notes did not indicate Hydromorphone 4 mg was given. The Controlled Substances Record on the same date indicated Hydromorphone 4 mg signed out by staff at 3:00 p.m., but the Medication Record did not indicate it was given.</p> <p>- On 10/10/13 at 4:00 p.m., the Pain Flow Sheet indicated a pain intensity of 8 out of 10 and Hydromorphone 4 mg was given. The Medication Record indicated Hydromorphone 4 mg was given. The Nurse's Medication Notes did not indicate Hydromorphone 4 mg was given. The Controlled Substances Record on the same date indicated Hydromorphone 4 mg was signed out by staff at 8:00 a.m., but the Medication Record did not indicate it was given.</p> <p>- On 10/11/13 at 7:18 a.m., the Medication Record indicated Hydromorphone 4 mg was given. The Pain Flow Sheet did not indicate her pain was assessed and the Nurse's Medication Notes did not</p>			

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	<p>indicate Hydromorphone 4 mg was given.</p> <p>- On 10/12/13 at 7:30 a.m. and 12:30 p.m., the Medication Record indicated Hydromorphone 4 mg was given. The Pain Flow Sheet did not indicate her pain was assessed and the Nurse's Medication Notes did not indicate Hydromorphone 4 mg was given.</p> <p>- On 10/16/13 at 5:20 p.m., the Pain Flow Sheet indicated a pain intensity of 8 out of 10 and Dilaudid 4 mg was given. The Medication Record indicated Hydromorphone 4 mg was given at 8:00 a.m., 12:15 p.m., and 5:20 p.m. The Nurse's Medication Notes indicated the Hydromorphone was given at 8:20 a.m., but did not indicate the Hydromorphone 4 mg was given at 12:15 p.m. and 5:20 p.m. The Pain Flow Sheet did not indicate her pain was assessed at 8:00 a.m. and 12:15 p.m.</p> <p>- On 10/18/13 the Medication Record indicated Hydromorphone 4 mg was given at 8:00 a.m. and 2:50 p.m. The Pain Flow Sheet did not indicate her pain was assessed at 8:00 a.m. and 2:50 p.m. and the Nurse's Medication Notes did not indicate Hydromorphone 4 mg was given.</p>			

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	<p>The Controlled Substances Record for the same date indicated Hydromorphone 4 mg was also signed out by staff at 8:02 p.m., but the Medication Record did not indicate it was given.</p> <p>- On 10/21/13 at 10:30 a.m., the Pain Flow Sheet indicated a pain intensity of 8 out of 10 and Hydromorphone 4 mg was given. The Medication Record indicated Hydromorphone 4 mg was given at 10:30 a.m. and 5:36 p.m. The Nurse's Medication Record indicated Hydromorphone 4 mg was given at 10:30 a.m. The Pain Flow Sheet did not indicate her pain was assessed at 5:36 p.m. The Controlled Substances Record on the same date indicated Hydromorphone 4 mg was also signed out by staff at 8:00 p.m., but the Medication Record did not indicate it was given.</p> <p>- On 10/23/13 the Pain Flow Sheet indicated a pain intensity of 9 out of 10 at 7:56 a.m. and 8 out of 10 on 8:20 p.m. The Medication Record indicated Hydromorphone 4 mg was given at 7:56 a.m. The Nurse's Medication Record indicated Hydromorphone 4 mg was given at 7:56 a.m. and 8:20 p.m. The Controlled Substances Record on the same date indicated Hydromorphone</p>			

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	<p>4 mg was signed out by staff at 7:56 a.m., 8:15 p.m., and also at 12:30 p.m., but the Medication Record did not indicate the Hydromorphone 4 mg at 12:30 p.m. was given.</p> <p>RN #5 was interviewed on 10/28/13 at 4:10 p.m. During the interview she indicated staff completed the Pain Flow Sheets to assess a resident's pain prior to giving pain medication. She also indicated any pain medication given to a resident was recorded on the Medication Record and the Nurse's Medication Notes were completed when a resident was given a PRN (as needed) pain medication.</p> <p>Resident #5 was interviewed on 10/29/13 at 8:40 a.m. During the interview she indicated she received her pain medication on a timely basis. She also indicated her pain was well controlled.</p> <p>3. Review of the clinical record for Resident #C on 10/24/13 at 9:30 a.m., indicated the following: diagnoses included, but were not</p>			

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	<p>limited to, pain, asymptomatic hypotension, nervous breakdown, MDD (Major Depression Disorder) with psychotic features, GERD (gastroesophageal reflux disease), encephalopathy, insomnia, pseudo dementia, anxiety.</p> <p>The Physician's Orders for 9/1/13 to 9/30/13 indicated Hydrocodone-APAP (Norco) 5/325 mg (milligrams) give 1 tablets orally every 8 hours PRN (as needed) for pain. The order was originally dated on 4/23/13.</p> <p>Review of the MARS (Medication Administration Record Sheet), the Pain Flow Sheet, the Nurse's Medication Notes, and the Controlled Substances Record for Resident #C, for the month of September, 2013, indicated the following discrepancies:</p> <ul style="list-style-type: none"> <li>- On 9/20/13 the MARS did not indicate Hydrocodone-APAP 5-325 mg was given. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg 1 tablet was signed out by staff at 9:30 a.m. and 8:00 p.m. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 9/20/13.</li> <li>- On 9/21/13 the MARS did not</li> </ul>			

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	<p>indicate Hydrocodone-APAP 5-325 mg was given. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tab was signed out by the staff at 8:00 p.m.. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 9/21/13.</p> <p>- On 9/22/13 the MARS did not indicate Hydrocodone-APAP 5-325 mg was given. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg 1 tablet was signed out by the staff at 9 a.m.. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Notes on 9/22/13.</p> <p>-On 9/23/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 3:45 p.m. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg 1 tablet was signed out at 8:00 a.m. and 3:45 p.m.. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 9/23/13.</p> <p>-On 9/24/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 4:00 p.m., The Controlled</p>			

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	<p>Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out 4:00 p.m., 11:00 p.m. and 7:00 a.m. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 9/24/13. The medication administration at 4:00 p.m. and 11:00 p.m. indicated the Hydrocodone-APAP-325 mg was given 7 hours apart.</p> <p>-On 9/25/13 MARS did not indicate the time of the administration, only the staff's initials. The Controlled Substances Record for the same dated indicated Hydrocodone-APAP 5-325 mg was signed out at 10:00 a.m., 4:00 p.m., and 10:00 p.m.. The medication administration times indicated the Hydrocodone-APAP 5-325 mg was given 6 hours apart. There was documentation on the Pain Flow Sheet at at 8:00 a.m. and 1:00 p.m. and no documentation at 10:00 p.m., 4:00 p.m. and 10:00 p.m. There was no documentation on the Nurses' Medication Note on 9/25/13.</p> <p>-On 9/26/13 MARS indicated Hydrocodone-APAP 5-325 mg, was given 9:00 a.m., 2:15 p.m., 8:00 p.m. The Controlled Substances Record on the same date indicated Hydrocodone-APAP 5/325 mg was</p>			

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	<p>signed out at 9:00 a.m., 2:15 p.m., 8:00 p.m.. The medication administration times indicated Hydrocodone-APAP 5-325 mg, was given 5 hours and 15 minutes and 5 hours and 45 minutes between doses consecutively. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 9/26/13.</p> <p>-On 9/27/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 7:00 a.m. and 11:00 a.m.. A review of the administration times 7:00 a.m. to 11:00 a.m., indicated Hydrocodone APAP 5-325 mg was given 4 hours apart. The Controlled Substances Record for the same date indicated the Hydrocodone-APAP 5-325 mg was signed out at 7:00 a.m., 11:00 a.m., and 5:00 p.m.. The medication administration times from 11:00 a.m. to 5:00 p.m. indicated the Hydrocodone-APAP 5-325 mg was given 6 hours apart. There was no documentation on the Pain Flow Sheet on 9/27/13 for 11:00 a.m. and 5:00 p.m.. There was no documentation on the Nurses' Medication Note on 9/27/13.</p> <p>-On 9/28/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 3:15 p.m.. The Controlled</p>			

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	<p>Substances Record for the same date indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 10:00 a.m., 3:00 p.m., and 3:15 p.m.. The medication administration times, 10:00 a.m. to 3:00 p.m. indicated the medication was given 5 hours apart and 3:00 p.m. to 3:15 p.m. indicated the medication was given 15 minutes apart. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 9/28/13.</p> <p>-On 9/29/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was administered 3 times, the first two entries were illegible and the third was given at 3:15 p.m. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg 1 tablet was signed out at 10:45 a.m. and 3:15 p.m.. The medication administration times, indicated the medication was given 4 1/2 hours apart. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 9/29/13.</p> <p>An interview with Regional DCS (Director of Clinical Services) on 10/25/13 at 11:00 a.m., looked at Resident #C's MARS and indicated she could not determine what time the Hydrocodone-APAP 5-325 mg</p>			

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	<p>was given to Resident #C on 9/29/13.</p> <p>An interview with LPN # 2 on 10/25/13 at 11:55 a.m., indicated she had given Resident #C Hydrocodone at 7:00 a.m. on 9/29/13, but she indicated she could not determine the other time written on the MARS on 9/29/13.</p> <p>-On 9/30/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:30 a.m., 2:00 p.m. and 8:15 p.m. The Controlled Substances Record indicated Hydrocodone-APAP 5-325 mg, 1 tablet was given at 7:30 a.m., 1:50 p.m. and 8:15 p.m. The medication administration times, 7:30 a.m. to 1:50 p.m., indicated the medication was given 6 hours and 20 min apart and 1:50 p.m. to 8:15 p.m., indicated the medication was given 6 hours and 25 minutes apart. There was no documentation on the Pain Flow Sheet on 9/30/13. There was no documentation on the Nurse's Medication Note at 8:15 p.m..</p> <p>Review of the MARS, the Pain Flow Sheet, the Nurse's Medication Notes, and the Controlled Substances Record for Resident #C, for the month of October, 2013, indicated the following discrepancies:</p>			

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	<p>-On 10/1/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 5:00 p.m. The Controlled Substances Record for the same date indicated the Hydrocodone -APAP 5-325 mg, 1 tablet was signed out at 7:00 a.m., 12:00 p.m. and 5:00 p.m.. The medication administration times, 7:00 a.m. to 12:00 p.m., indicated the medication was given 5 hours apart and 12:00 p.m. to 5:00 p.m. the medication was given 5 hours apart. There was lack of documentation on the Pain Flow Sheet at 5:00 p.m. There was no documentation on the Nurses' Medication Note on 10/1/13.</p> <p>-On 10/2/13 there was no documentation on the Pain Flow Sheet at 3:00 p.m. when Hydrocodone-APAP 5-325 mg was given. There was no documentation on the Nurses' Medication Note on 10/2/13.</p> <p>-On 10/3/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m.. The Controlled Substances Record for the same date indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 7:05 a.m. and 1:00 p.m.. The medication administration times indicated the medication was given 6 hours apart. There was no</p>			

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	<p>documentation on the Pain Flow Sheet at 1:00 p.m. and there was no documentation on the Nurses' Medication Note on 10/3/13.</p> <p>-On 10/4/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m. and 11:00 a.m.. The medication administration times indicated the medication was given 4 hours apart. The Controlled Substances Record indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 7:15 a.m., 1:30 p.m. and 9:45 p.m. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 10/4/13.</p> <p>-On 10/6/13 there was no documentation on the Pain Flow Sheet when Hydrocodone-APAP 5-325 mg, 1 tablet was given at 11:00 a.m.</p> <p>-On 10/7/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m., 1:00 p.m., 8:00 p.m.. The medication administration times, 7:00 a.m. to 1:00 p.m., indicated the medication was given 6 hours apart and 1:00 p.m. to 8:00 p.m. the medication was given 7 hours apart. The Controlled Substances Record on the same date</p>			

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	<p>indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 6:50 a.m., 11:30 a.m. and 8:00 p.m. There was no documentation on the Nurses' Medication Note on 10/7/13.</p> <p>-On 10/8/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m.. The Controlled Substances Record indicate Hydrocodone-APAP 5-325 mg, 1 tablet at 7:00 a.m., 12:30 p.m., and 8:30 p.m. The medication administration times 7:00 a.m. to 12:30 p.m., indicated the medication was given 5 and 1/2 hours apart. There was no documentation on the Pain Flow Sheet at 7:00 a.m. and there was no documentation on the Nurses' Medication Note on 10/8/13.</p> <p>-On 10/10/13 there was no documentation on the Pain Flow Sheet on 10/10/13 when Hydrocodone-APAP 5-325 mg was given at 2:30 p.m. There was no documentation on the Nurses' Medication Note on 10/10/13.</p> <p>-On 10/11/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 7:00 a.m. and 3:00 p.m.. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1</p>			

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	<p>tablet was signed out at 10:00 a.m. and 3:00 p.m.. The medication administration times 10:00 a.m. to 3:00 p.m., indicated the medication was given 5 hours apart. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 10/11/13.</p> <p>-On 10/12/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m.. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 7 a.m. and "Pp" [sic], an illegible time. Could not determine the time the medication was signed out. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Notes on 10/12/13.</p> <p>-On 10/13/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m.. The Controlled Substances Record for the same date, indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 6:00 a.m., 2:00 p.m. and 9:00 p.m.. The medication administration times indicated the medication was given 7 hours apart. There was no documentation on Pain Flow Sheet at 9:00 p.m., and there was no documentation on the Nurses's</p>			

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	<p>Medication Note on 10/13/13.</p> <p>-On 10/14/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 6:00 a.m.. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 6:00 a.m. and 8:00 p.m. There was no documentation on the Pain Flow Sheet at 8:00 p.m. There was no documentation on the Nurses' Medication Note on 10/14/13.</p> <p>-On 10/15/13 there was no documentation on the Pain Flow Sheet or the Nurses' Medication Note for Hydrocodone-APAP 5/325 mg given at 7:30 a.m. and 3:30 p.m.</p> <p>-On 10/16/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:00 a.m. and the Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg was signed out at 7:30 a.m., 3:00 p.m. and 10:05 p.m.. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 10/16/13.</p> <p>-On 10/17/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 8:00 a.m. and 7:00 p.m.. The Controlled Substances Record</p>			

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	<p>indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 8 a.m. and 3:25 p.m. There was no documentation on the Pain Flow Sheet on 10/17/13.</p> <p>On 10/18/13 the MARS indicated the Hydrocodone-APAP 5-325 mg was given at 7:30 a.m. and 3:30 p.m.. The Controlled Substances Record indicated Hydrocodone-APAP 5-325 mg, 1 tablet was signed out at 7:30 a.m., 3:00 p.m. and 7:10 p.m.. There was no documentation on the Pain Flow Sheet at 7:30 a.m. or 7:10 p.m., and there was no documentation on the Nurses' Medication Note on 10/18/13.</p> <p>A Physician's order dated 10/19/13 indicated, "... Hydrocodone-APAP 5-325 mg, give 2 tablets po (orally) q (every) 6 hours PRN (as needed) for moderate to severe pain."</p> <p>The Nurses Progress Note dated 10/19/13 at 5:30 p.m. indicated, "...Resident has been complaining of increased pain and current PRN pain med (medication) not effective. Dr. notified. N.O.'s (New Order) were obtained at 10 a.m. for Hydrocodone-APAP 5/325 give 2 tabs po q 6 hr prn moderate - severe pain. Res notified at that time."</p>			

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	<p>-On 10/19/13 the MARS indicated the Hydrocodone-APAP 5-325 mg, 1 tablet was given at 7:00 a.m. and 3:00 p.m.. The Controlled Substances Record on the same date indicated Hydrocodone-APAP 5/325 mg, 1 tablet was signed out at 8:00 a.m., 3:00 p.m. and 2 tablets at 9:00 p.m. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 10/19/13.</p> <p>-On 10/20/13 the MARS indicated Hydrocodone-APAP 5-325 mg, 2 tablets were given at 8:00 a.m. and Hydrocodone-APAP 5-325 mg, 1 tablet was given at 3:00 p.m.. The Controlled Substances Record on the same date indicated Hydrocodone-APAP 5/325, 2 tablets were signed out at 7:00 a.m. and 3:00 p.m.. There was no documentation on the Pain Flow Sheet on 10/20/13.</p> <p>-On 10/21/13 the MARS indicated Hydrocodone-APAP 5-325 mg, 2 tablets were given at 7:30 a.m. and Hydrocodone-APAP 5-325 mg, 1 tablet was given at 3:00 p.m.. The Controlled Substances Record on the same date indicated Hydrocodone-APAP 5/325 mg, 2 tablets were signed out at 7:30 a.m. and 3:00 p.m.. There was no</p>			

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	<p>documentation on the Pain Flow Sheet or the Nurses' Medication Note on 10/21/13.</p> <p>-On 10/22/13 the MARS indicated Hydrocodone-APAP 5-325 mg, 2 tablets were given at 7:30 a.m. and 1:45 p.m., Hydrocodone-APAP 5-325 mg, 1 tablet was given at 3 p.m.. The medication administration times, 7:30 a.m. to 1:45 p.m., indicated the medication was given 6 hr and 15 minutes between doses and 1:45 a.m. to 3:00 p.m. indicated the medication was given 1 hour and 15 minutes apart. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 2 tablets was signed out at 7:30 a.m. and 1:45 p.m., There was not a dose signed out at 3:00 p.m. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 10/22/13.</p> <p>-On 10/23/13 the MARS indicated Hydrocodone-APAP 5-325 mg, 2 tablets were given at 7:15 a.m. and Hydrocodone-APAP 5-325 mg, 1 tablet was given at 3:30 p.m.. The Controlled Substances Record on the same date indicate Hydrocodone-APAP 5-325 mg, 2 tablets were signed out at 7:15 a.m. There was not a dose of</p>			

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	<p>Hydrocodone signed out at 3:30 p.m. on 10/23/13. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 10/23/13.</p> <p>- On 10/24/13 The MARS indicated no Hydrocodone was given. The Controlled Substances Record on the same date indicated Hydrocodone-APAP 5-325 mg, 2 tabs were signed out at 3:25 p.m., 2 tabs at 7:15 a.m. and 3:30 p.m. There was no documentation on the Pain Flow Sheet or the Nurses' Medication Note on 10/24/13.</p> <p>4. During a clinical record review for photographs on the TARS (Treatment Administration Record Sheet) for the West Hall on 10/28/13 at 1:15 p.m. these discrepancies were found:</p> <p>- Resident #G 's photograph was placed under the divider tab for the wrong room in the TARS.</p> <p>-Resident #H 's photograph was placed under the divider tab for wrong room in the TARS.</p> <p>During an interview with LPN #2 on 10/28/13 at 1:25 p.m., she indicated the photograph of the resident was to be placed under the divider tab of</p>			

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	<p>their room number in the MARS and TARS. LPN #2 reviewed the TARS for the West Hall and indicated the photographs for Resident #G and Resident #H were placed under the wrong divider tab.</p> <p>5. The record review for Resident #E began 10-24-2013 at 3:28 p.m. Diagnoses included but were not limited to: arteriosclerotic cardiovascular disease, morbid obesity, chronic kidney disease, tracheostomy, gastrostomy, diabetes, chronic depression, peripheral vascular disease, osteoarthritis of the knees, aphasia, history of multiple cerebral vascular accidents, hypertension, recurrent bronchopneumonia, obstructive sleep apnea, right hemiplegia and hypertensive cardiovascular disease.</p> <p>The MDS (Minimum Data Set) significant change assessment done on 8-5-2013 for Resident #E indicated a BIMS (Brief Interview of Mental Status assessment that measures cognitive level) score of "rarely/never is understood".</p> <p>A review of the physician's</p>			

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	<p>recapitulation for September 2013 and October 2013 indicated Resident #E had PRN (as needed) narcotic pain medication ordered as followed: "Hydrocodone - APAP 5-325 mg (Norco) give 1 tablet orally every 8 hours as needed for pain".</p> <p>A review of the Medication Administration Record (MAR), the Pain Flow Sheet, the Controlled Substances Record and the Nurse's Medication Notes for Resident #E, from September 20, 2013 and forward indicated the following discrepancies for Resident #E's hydrocodone:</p> <p>On 9-20-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet indicated hydrocodone was given at 2:00 a.m., the Nurse's Medication Notes did not indicate the pain medication was administered and the Controlled Substances Record indicated the hydrocodone was signed out at 2:30 a.m. and 4:00 p.m.</p> <p>On 9-21-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate</p>			

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	<p>hydrocodone was administered, and the Controlled Substances Record indicated the hydrocodone was signed out at 8:00 a.m. and 3:00 p.m.</p> <p>On 9-22-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet indicated hydrocodone was given at 12:00 a.m., the Nurse's Medication Notes did not indicate hydrocodone was given and the Controlled Substances record indicated hydrocodone was signed out at 12:00 a.m.</p> <p>On 9-23-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet indicated hydrocodone was given at 12:15 a.m., the Nurse's Medication Notes did not indicate hydrocodone was given and the Controlled Substances record indicated hydrocodone was signed out at 12:15 a.m. and 10:00 (a.m. or p.m. was not indicated).</p> <p>On 9-24-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substances Record</p>			

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	<p>indicated hydrocodone was signed out at 8:00 a.m. and 5:00 p.m.</p> <p>On 9-25-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet indicated hydrocodone was administered at 2:00 a.m., the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 2:00 a.m. and 4:00 p.m.</p> <p>On 9-26-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 6:00 a.m. and 12:00 (a.m. or p.m. not legible).</p> <p>On 9-27-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 8:00 a.m. and 4:00 p.m.</p>			

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	<p>On 9-28-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 6:00 a.m.</p> <p>On 9-29-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 6:00 a.m. and 1:30 p.m.</p> <p>On 10-2-2013, the MAR indicated the hydrocodone was administered at 10:15 a.m., the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substance Record indicated hydrocodone was signed out at 10:00 a.m.</p> <p>On 10-4-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's</p>			

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	<p>Medication Notes did not indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 9:40 p.m.</p> <p>On 10-6-2013, the MAR indicated hydrocodone was administered at 3:00 a.m., the Pain Flow Sheet indicated hydrocodone was administered at 3:00 a.m., the Nurse's Medication Notes did not indicate the hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 3:00 a.m.</p> <p>On 10-7-2013, the MAR indicated hydrocodone was administered at 7:30 a.m. and 4:00 p.m., the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substances Record indicated hydrocodone was signed out at 7:00 a.m.</p> <p>On 10-9-2013, the MAR indicated hydrocodone was administered at 10:00 a.m., the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substances Record indicated</p>			

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	<p>hydrocodone was signed out at 9:30 a.m.</p> <p>On 10-10-2013, the MAR indicated hydrocodone was administered at 9:15 p.m., the Pain Flow Sheet indicated hydrocodone was administered at 10:00 a.m., the Nurse's Medication Notes did not indicate the the resident was administered hydrocodone and the Controlled Substances Record indicated hydrocodone was signed out at 9:15 p.m.</p> <p>On 10-11-2013, the MAR indicated hydrocodone was administered at 10:00 a.m., the Pain Flow Sheet indicated hydrocodone was administered at 10:00 a.m., the Nurse's Medication Notes did not indicate the resident was administered hydrocodone and the Controlled Substances Record indicated hydrocodone and the Controlled Substances Record indicated hydrocodone was signed out at 10:00 a.m. and 9:15 p.m.</p> <p>On 10-12-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and</p>			

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	<p>the Controlled Substances records indicated hydrocodone was signed out at 6:00 a.m.</p> <p>On 10-13-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substance records indicated hydrocodone was signed out at 12:00 a.m.</p> <p>On 10-14-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substance Notes indicated hydrocodone was signed out at 12:00 a.m. and 6:00 a.m.</p> <p>On 10-15-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substance Notes indicated hydrocodone was signed out at 1:00 a.m.</p> <p>On 10-17-2013, the MAR indicated</p>			

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	<p>hydrocodone was administered at 10 a.m., the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substance Notes indicated hydrocodone was signed out at 10 a.m.</p> <p>On 10-22-2013, the MAR indicated hydrocodone was administered at 4:00 a.m., the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substance Notes did not indicate hydrocodone was signed out on 10-22-2013.</p> <p>On 10-23-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and the Controlled Substance Notes indicated hydrocodone was signed out at 4:00 a.m.</p> <p>On 10-24-2013, the MAR lacked documentation to indicate hydrocodone was administered, the Pain Flow Sheet and the Nurse's Medication Notes did not indicate hydrocodone was administered and</p>			

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	<p>the Controlled Substance Notes indicated hydrocodone was signed out at 11:00 p.m. and 7:00 a.m.</p> <p>During an interview with LPN #2 on 10-28-2013 at 1:21 p.m., the LPN indicated the administration of hydrocodone for Resident #E should be documented in the narcotic book (Controlled Substance Record), the MAR and the Pain Flow Sheet. The LPN indicated she did not consistently document the administration of the hydrocodone on the Pain Flow Sheet.</p> <p>During an interview with the Interim Director of Clinical Services (DCS) on 10-28-2013 at 1:24 p.m., the DCS indicated she was aware the nursing staff was not consistently documenting the pain medication use on all of the required documentation forms for pain and for the nebulizer treatments. The DCS indicated the facility did not have a policy regarding the documentation, but had a plan. The DCS indicated staff was instructed on the plan for documentation expectations last week as followed: "...all documentation is to be completed timely: i.e. prn documented at time of administration - to be signed out on MAR, back of MAR, Pain Flow Sheet,</p>				

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	<p>Narcotic Control Record, etc., assessments to be documented on MAR, Respiratory Flow Sheet, Nurses' Note...."</p> <p>During an interview with LPN #3 on 10-28-2013 at 1:30 p.m., the LPN indicated the documentation for PRN pain medications should be done on the narcotic count sheet (Controlled Substance Record), the MAR--front and back, the Pain Flow Sheet, the 24 hour report and in the nurse's notes. For routine pain meds, the LPN indicated documentation would be on the MAR and on the narcotic count sheet (Controlled Substance Record).</p> <p>6. The record review for Resident #F began on 10-23-2013 at 12:23 p.m. Resident #F was admitted 9-20-2013 with diagnoses included but not limited to, morbid obesity, diabetes, shortness of breath/edema and depression.</p> <p>The MDS (Minimum Data Set) admission assessment on 10-1-2013 indicated Resident #F had a BIMS (Brief Interview for Mental Status- that measures cognitive status) score was 15/15, indicating the resident was alert and oriented.</p>			

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	<p>A review of the Physician Recapitulation for October 2013 indicated orders for Iprat-albut (respiratory medication) 0.5-3(2.5) mg (milligrams)/3 ml(milliliter)---Duoneb (respiratory medication)--inhale 1 ampule via nebulizer every 6 hours as needed.</p> <p>During an interview with LPN #3 on 10-23-2013 at 12:15 p.m., the LPN indicated Resident #F received breathing treatments as needed and the last treatment was on 10-21-2013. LPN #3 indicated prior to the breathing treatment a respiratory assessment was done that included breath sounds, respiration rate, heart rate and pulse oximetry. LPN #3 indicated the respiratory assessment was done after the treatment.</p> <p>During an interview with LPN #4 on 10-23-2013 at 4:15 p.m., the LPN indicated for a resident who received a breathing treatment, the respirations, pulse and lung sounds are checked prior to, during and after the treatment. LPN #4 indicated the prior to and after respiratory assessments were documented on the Nebulizer Treatment Flow Sheet.</p> <p>A review of the October 2013 Medication Administration Record</p>				

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	<p>and the Nebulizer Treatment Flow Sheet indicated the following lack of documentation:</p> <p>On 10-1-2013, the MAR indicated a nebulizer treatment was administered at 5 p.m. and the Nebulizer Treatment Flow Sheet lacked a respiratory assessment prior to and post administration.</p> <p>On 10-2-2013, the MAR indicated a nebulizer treatment was administered at 3 p.m. and the Nebulizer Treatment Flow Sheet lacked a respiratory assessment prior to and post administration.</p> <p>On 10-3-2013, the MAR indicated a nebulizer treatment was administered at 6:00 a.m. and 4:00 p.m. The Nebulizer Treatment Flow Sheet had a 6:30 a.m. respiratory assessment prior to and post administration documented but lacked the 4:00 p.m. prior to and post respiratory assessment.</p> <p>On 10-4-2013, the MAR lacked documentation a nebulizer treatment was administered, but the Nebulizer Treatment Flow Sheet indicated documentation for a respiratory assessment prior to a nebulizer treatment.</p>			

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	<p>On 10-9-2013, the MAR indicated nebulizer treatments were administered at 9:30 a.m. and 5:30 p.m. and the Nebulizer Treatment Flow Sheet lacked documentation of a respiratory assessment prior to and post administration.</p> <p>On 10-10-2013, the MAR indicated a nebulizer treatment was administered at 4:00 p.m. and the Nebulizer Treatment Flow Sheet lacked documentation of a respiratory assessment prior to and post administration.</p> <p>On 10-12-2013, the MAR indicated a nebulizer treatment was administered at 3:40 p.m. and the Nebulizer Treatment Flow Sheet lacked documentation of a respiratory assessment prior to and post administration.</p> <p>On 10-16-2013, the MAR lacked documentation a nebulizer treatment was administered, but the Nebulizer Treatment Flow Sheet indicated documentation of a respiratory assessment prior to and post administration at 8:00 a.m.</p> <p>On 10-20-2013, the MAR lacked documentation a nebulizer treatment</p>						

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	<p>was administered, but the Nebulizer Treatment Flow Sheet indicated documentation of a respiratory assessment prior to and post administration at 12:00 (a.m. or p.m. not indicated).</p> <p>On 10-21-2013, the MAR indicated a nebulizer treatment was administered at 11:30 a.m. and the Nebulizer Treatment Flow Sheet lacked documentation of a respiratory assessment prior to and post administration.</p> <p>During an interview with LPN #3 on 10-24-2013 at 10:10 a.m., LPN #3 indicated the breathing treatment assessment should have been documented on the Nebulizer Treatment Flow Sheet. The LPN indicated the respiratory assessment was not documented for some of the dates that the nebulizer treatment was given for Resident #F.</p> <p>During an interview with LPN #4 on 10-24-2013 at 2:10 p.m., LPN #4 indicated she had been conducting the MAR (Medication Administration Record/nebulizer treatment prior and post assessment audits. The LPN indicated if the information was not on the Nebulizer Treatment Flow sheet for the prior to and post respiratory</p>						

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	<p>treatment assessment, then it was not done or the nurse could have written it on the daily assignment sheet and forgot to transfer it to the Nebulizer Treatment Flow sheet. The LPN indicated the staff had been inserviced about the importance on getting the documentation down on the flow sheets.</p> <p>During an interview with LPN #3 on 10-24-2013 at 3:00 p.m., the LPN indicated when she did the nebulizer treatment for the Resident #F, she did do the prior to and post respiratory assessments and documented the information on her nursing assignment sheet. The LPN indicated she did not transfer respiratory assessment over to the Nebulizer Treatment Flow sheet.</p> <p>During an interview with LPN #2 on 10-25-2013 at 9:05 a.m., the LPN indicated a respiratory assessment was done prior to and post administration of the nebulizer treatment. The LPN indicated she documented the results of the respiratory assessment on the nurse assignment sheet (not part of the resident record) but did not transfer the documentation over to the Nebulizer Treatment Sheet.</p>						

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	<p>The current "Hand Held Nebulizer" policy dated 1-1-2009 and provided by the MDS Coordinator on 10/28/13 at 11:40 a.m., indicated to "...establish baseline respiratory rate, heart rate and breath sounds...administer treatment...monitor resident's heart rate before, during and after...assess the resident's response and effectiveness of the treatment by assessing breath sounds before and after...document treatment in the resident's medical record...."</p> <p>Confidential interviews with sixteen residents, identified by the facility as alert and oriented, were conducted on 10/29/13 between 8:00 a.m. and 9:00 a.m.. Each resident interviewed indicated they received their pain medications on a timely basis. They also indicated their pain was well-controlled.</p> <p>This deficiency was cited on 8/21/13 and the facility failed to implement the plan to correct the deficiency.</p> <p>3.1-50(a)(1)</p>				

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F000520 SS=E	<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> <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 record review and interview, the facility Quality Assessment and Assurance (QAA) Committee failed to identify and implement a plan of action for the identified concerns of: following physician orders, lack of documentation on MARS (Medication Administration Record), the Pain Flow Sheet, the Nurses' Medication Notes and to monitor the complete and accurate documentation of narcotic</p>	F000520	F520 1. The initial report was filed on 10/28/2013 and the final reported on 10/29/2013 by the Executive Director. To address the accuracy of the laboratory results, the labs were rerun and the results were inline with administration of prescribed medication. The amphetamines that were originally reported as present were not present when the test was rerun. The findings were reviewed by the staff nurse and the Director of Clinical Services (DCS) and have been	11/20/2013	

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	<p>administration. This deficient practice had the potential to affect 41 of 41 residents residing in the facility.</p> <p>Findings include:</p> <p>A review of the Facility's Plan of Correction that was provided by the facility on 10/24/13, indicated all the staff was educated by 9/20/13 on implementation of MD (Medical Doctor) orders, medication and treatment administration documentation and change over (nurse's shift change). The Plan of Correction indicated , "All medications and treatments will be administered per MD order as indicted on the MAR (Medication Administration Record) or TAR (Treatment Administration Record). The DCS (Director of Clinical Services) and or a licensed nurse will review all MAR's and TAR's daily to validate medications and treatments were administered....Each licensed staff is responsible to review the MAR and TAR prior to the end of each shift to validate all medications and treatments were administered....Any discrepancies identified will be corrected immediately.</p> <p>Based on review of the clinical records there was no indication or</p>		<p>reported to the physician. Residents D and C showed no apparent adverse effects. Residents D and C's Physicians and Responsible parties were notified of medication administration discrepancies by the DCS on November 15, 2013 and any new orders given to the nurse by the physicians were received, noted, and implemented at that time. Residents B, C, D, &amp; E showed no apparent adverse effect. Residents B, C, D, &amp; E's physicians and Responsible Parties were notified of medication administration discrepancies by the DCS on November 15, 2013 and any new orders given to the nurse by the physicians were received, noted, and implemented at that time. Residents B, C, D, E &amp; F showed no apparent adverse effect. The correct photograph has been placed under the correct divider tab in the Treatment Administration Record (TAR) for Resident G. The correct photograph has been placed under the correct divider tab in the TAR for Resident H. Residents G and H suffered no harm. 2. All residents have the potential to be affected 3. The Executive Director and the Department Heads were re-educated on regulation F520 and the facility's policy on 11/12/2013 by the RDCS. 4. The Regional</p>		

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	<p>documentation the QAA Committee was monitoring the orders and distribution to residents of narcotic medications.</p> <p>An interview with the Interim DCS (Director of Clinical Services) on 10/28/13 at 1:30 p.m., indicated the licensed nurse staff was re-educated on 10/24/13 regarding timely documentation. Timely documentation included PRN (as needed) medications which needed to be documented at time of administration and be signed out on the MAR, on the back of the MAR, the Pain Flow Sheet, the Narcotic Control Record.</p> <p>An interview with the Executive Director on 10/29/13 at 1:25 p.m., indicated the Quality Assessment and Assurance Committee had just revised and implemented action plans on 10/24/13 and began to re-educate the licensed nurses to address deficient practice in the following areas: All documentation was to be completed timely and PRN to be documented at time of administration, to be signed out on MAR, back of MAR (Nurses' Medication Note), the Pain Flow Sheet and the Narcotic Control Record</p>		<p>Vice-President of Operations (RVPO)/RDCS will monitor the QAPI monthly times six months to ensure substantial compliance. A member of the regional team will attend two quarterly QAPI committee meetings. The QAPI committee will determine if further action is indicated.</p> <p>5. Compliance date: 11/20/2013</p>	

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F009999	3.1-52(b)(2)	F009999	no citation found to respond too	11/20/2013	