

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/12/2015
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00163746 and Complaint IN00164122..</p> <p>Complaint IN00163746 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F164, F241, F246, F282, F441 and F514.</p> <p>Complaint IN00164122 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F241, F282 and F514.</p> <p>Survey dates: February 10, 11 and 12, 2015</p> <p>Facility number: 000135 Provider number: 155230 AIM number: 100266820</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 10 SNF/NF: 95 Total: 105</p> <p>Census payor type: Medicare: 26</p>	F 000	<p>This Plan of Correction constitutes the centers Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 157 SS=D Bldg. 00	<p>Medicaid: 54 Other: 25 Total: 105</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 22, 2015 by Cheryl Fielden, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as</p>				

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	<p>specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure timely notification of the attending physician for 1 of 4 residents reviewed for pain, in a sample of 7, who had multiple doses of a narcotic pain reliever not documented as administered as ordered over a 4 day period. This deficient practice has the potential to adversely affect the pain level of the resident, resulting in the resident being in pain and/or discomfort and possibly result in inappropriate care related to lack of the attending physician not being properly informed of the resident's pain status. (Resident #D)</p> <p>Findings include:</p> <p>On 2-10-15 at 2:35 p.m., the clinical record of Resident #D was reviewed. Her diagnoses included, but were not limited to, generalized pain,</p>	F 157	<p>F157</p> <p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Resident #D's Physician was made aware of medication errors, and resident #D is receiving medication as prescribed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>All residents have the potential to be affected. DNS conducted 100% audit of residents' narcotic pain medication supply to ensure availability and medications administered and documented on MAR and Narcotic count record per physician order.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p>	03/13/2015

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	<p>osteoarthritis, bilateral edema (swelling) of the lower extremities and muscle atrophy. Her most recent Minimum Data Set (MDS) assessment, dated 11-13-14, indicated she was moderately cognitively intact. She required extensive assistance of 2 or more persons for bed mobility, does not ambulate, requires the use of a wheelchair for mobility and received routinely scheduled pain medication. In an interview with LPN #1 on 2-10-15 at 11:00 a.m., during the initial tour of the facility, she identified Resident #D as being alert and oriented to person, place and time, as well as receiving routinely scheduled pain medication for generalized pain.</p> <p>In an interview with Resident #D on 2-11-15 at 1:57 p.m., she indicated she experiences a great deal of arthritic pain of her knees and legs. She explained that she usually receives her pain medication every 4 hours, "but I think sometimes they [facility staff] forget [to administer] it."</p> <p>In review of the Medication Administration Record (MAR) for January, 2015 and the corresponding narcotic administration log for Resident #D, it indicated during the time period of 1-16-15 and 1-20-15, several doses could not clearly be ascertained as administered</p>		<p>Nursing staff re-educated by 3/13/15 on Physician Notification Policy and importance of timely reporting of medication errors and unavailability of medication as well as properly documenting administration on MAR and Narcotic count record per physician order. MAR/TAR will be reviewed by Nurse Management Team / Weekend Nurse Manager daily to ensure physician updated timely if medication refill orders are needed or medication errors occur as well as ensure that medication administration documented on MAR and Narcotic count record.</p> <p>How will the corrective actions be monitored to ensure they do not occur again?</p> <p>A Physician Notification / MAR / Narcotic Count Record CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor for timely Physician notification of medication errors and properly documenting administration on MAR and Narcotic count record per physician order. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>	

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	<p>to the resident for the physician ordered medication of Norco 10/325 milligrams (mg) every 4 hours while awake. The administration times listed for this medication were documented as 2:00 a.m., 6:00 a.m., 10:00 a.m. 2:00 p.m., 6:00 p.m., 10:00 p.m.</p> <p>The narcotic administration log is utilized to document each time a dose of the specific narcotic for a specific resident is taken from its corresponding package in order to keep a detailed record of the narcotic. The narcotic administration log for Resident #D's Norco 10/325 mg indicated the following:</p> <p>-1-16-15 at 6:00 a.m., was documented as administered.</p> <p>1-16-15 at 2:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m., had no information listed to acknowledge Resident #D received the ordered dose of Norco 10/325 mg.</p> <p>-1-16-15 at 10:00 p.m., an EDK (Emergency Drug Kit) acknowledgement slip indicated authorization was provided for one dose of Norco 10/325 mg to be provided to Resident #D.</p> <p>-1-17-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 10:00 p.m., were documented as administered. The 6:00 p.m., dose was not documented as administered.</p> <p>-1-18-15 at 2:00 a.m., 6:00 a.m., 10:00</p>			

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	<p>a.m., 2:00 p.m., and 6:00 p.m., were documented as administered. The 10:00 p.m., dose was not documented as administered.</p> <p>-1-19-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m., were not documented as administered.</p> <p>-1-20-15 at 2:00 a.m., 6:00 a.m., and 10:00 a.m., were not documented as administered. The doses for 2:00 p.m., 6:00 p.m., and 10:00 p.m., were documented as administered.</p> <p>The corresponding MAR for January, 2015 for Resident #D contained many small boxes which made the document very difficult to read. The information for the physician ordered Norco 10/325 mg every 4 hours while awake indicated the following:</p> <p>1-16-15 at 2:00 a.m., the staff member's initials were listed in the appropriate box to indicate it had been administered to the resident. However, the narcotic administration record contained no information to acknowledge Resident #D received the ordered dose of Norco 10/325 mg.</p> <p>-1-16-15 at 6:00 a.m., a blank box, indicating a lack of initials of the staff member, thus indicating the medication was not administered to the resident.</p> <p>1-16-15 at 10:00 a.m., 2:00 p.m. and 6:00</p>			

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	<p>p.m. encircled initials of the staff member were in the appropriate boxes. Encircled initials of the staff member indicates the medication was not provided to the resident.</p> <p>-1-16-15 at 10:00 p.m., an EDK (Emergency Drug Kit) acknowledgement slip indicated authorization was provided for one dose of Norco 10/325 mg to be provided to Resident #D.</p> <p>-1-17-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 10:00 p.m., were documented as administered. The 6:00 p.m., dose was not documented as administered.</p> <p>-1-18-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m., were documented as administered. The 10:00 p.m., dose was not documented as administered.</p> <p>-1-19-15 The medication was documented as administered at 2:00 a.m., 6:00 a.m., 10:00 a.m., and 2:00 p.m. The medication was documented as not administered at 6:00 p.m., and 10:00 p.m.</p> <p>-1-20-15 at 6:00 a.m., a blank box, indicating a lack of initials of the staff member.</p> <p>-1-20-15 at 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m., doses were documented as administered.</p> <p>The back side of the MAR is typically utilized by staff to explain in narrative</p>			

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F 164 SS=D Bldg. 00	<p>form a detailed accounting of why a medication was administered or not administered to a resident. The back sides of the MAR for January, 2015 were blank in regard to the Norco 10/325 mg. Additionally, documentation in Resident #D's clinical record did not indicate any issues related to the resident not receiving the Norco 10/325 mg as ordered, nor did it indicate Resident #D's attending physician or the resident were notified of the multiple doses of the medication being unavailable or not administered.</p> <p>On 2-12-15 at 10:20 a.m., the Director of Nursing Services provided a copy of a policy entitled, "Change of Condition." This policy had a revision date of 3-10, and was indicated to be the current policy in force for the facility. This policy indicated, "It is policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs..."</p> <p>This Federal tag relates to Complaint IN00163746 and Complaint IN00164122.</p> <p>3.1-5(a)(3)</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p>			

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	<p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure health related information was carefully protected from the public's ability to view their information for 2 of 32 residents on 1 of 4 hallways during 1 of 4 observations of the facility. (Residents #F and #G)</p> <p>Findings include:</p>	F 164	<p>F164</p> <p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>C Hall Residents #F & #G information was immediately covered by nurse upon awareness of concern.</p> <p>How other residents having the potential to be affected by the same deficient practice will be</p>	03/13/2015

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	<p>1. During a routine tour of the facility on 2-11-15 at 7:47 p.m., on Hall C, a medication cart was observed to be unsupervised with the narcotic administration log open and easily viewable by a passer-by for Resident #F's information regarding a physician order for clonazepam (an anti-anxiety medication) 0.5 milligrams twice daily by mouth. It documented 9 doses of this medication were received by the resident since 2-2-15.</p> <p>In interview with LPN #5 on 2-11-15 at 7:52 p.m., she indicated she was in a hurry to provide care to a resident and failed to close the log.</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration.</p> <p>On 2-12-15 at 2:23 p.m., the DNS provided a copy of a document entitled, "HIPAA [Health Insurance Portability and Accountability Act] General Orientation Training for Frontline Staff." She indicated this document is provided to staff during orientation. The document indicated, "What is Confidential: All</p>		<p>identified and what corrective action will be taken? All residents have the potential to be affected. DNS conducted 100% audit of residents' MAR/TAR to ensure all resident specific information was not viewable to others.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Nursing staff re-educated by 3/13/15 on HIPAA and ensuring that resident information is not viewable to others and five rights of medication administration. Daily Rounds by Nurse Management Team / Weekend Nurse Manager to monitor for MAR/TAR or other resident information to ensure it is not visible to others and to monitor medication administration five rights are followed.</p> <p>How will the corrective actions be monitored to ensure they do not occur again? A HIPAA / Five Rights of Medication Administration CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor for HIPAA and five rights of medication administration compliance. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>				

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	<p>information about residents is considered private or 'confidential.', whether on paper, faxed. saved on a computer, spoken aloud. Includes their name, address, age, social security number, reason is at facility, treatments and medications they receive, caregivers' notes, and past history..."</p> <p>2. During a routine tour of the facility on 2-11-15 at 7:47 p.m., on Hall C, a medication cart was observed to be unsupervised with the Medication Administration Record (MAR) open and easily viewed for Resident #G's information on "page 2 of 6" of the MAR. The entries for this page included the following information and physician orders:</p> <ul style="list-style-type: none"> -the full name of Resident #G, her date of birth, room number, name of her attending physician, diagnoses, date of admission and drug allergies. -occupational therapy orders for 5 times weekly for 8 weeks for therapeutic exercise and activities of daily living. -Duoneb solution inhale 1 vial via nebulizer 4 times daily for shortness of breath/COPD. -sodium bicarbonate 650 milligrams (mg) one tablet by mouth once daily. -I-Vite one tablet by mouth once daily for macular degeneration. -acetaminophen 325 mg two tablets (650) 			

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	<p>mg by mouth twice daily for osteoarthritis.</p> <p>-allopurinol 100 mg by daily by mouth in the morning.</p> <p>In interview with LPN #5 on 2-11-15 at 7:52 p.m., she indicated she was in a hurry to provide care to a resident and failed to close the log.</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration.</p> <p>On 2-12-15 at 2:23 p.m., the DNS provided a copy of a document entitled, "HIPAA [Health Insurance Portability and Accountability Act] General Orientation Training for Frontline Staff." She indicated this document is provided to staff during orientation. The document indicated, "What is Confidential: All information about residents is considered private or 'confidential.', whether on paper, faxed. saved on a computer, spoken aloud. Includes their name, address, age, social security number, reason is at facility, treatments and medications they receive, caregivers' notes, and past history..."</p>			

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	<p>3. During a routine tour of the facility on 2-11-15 at 7:47 p.m., on Hall C, a medication cart was observed to be unsupervised with the Medication Administration Record (MAR) and narcotic administration log open and easily viewable by a passer-by. One narcotic record was observable for Resident #F in the narcotic administration record and one page of Resident #G's MAR was observable. Additionally, a single page of resident names, of at least 15 full names of current residents, was also observable by a passer-by.</p> <p>In interview with LPN #5 on 2-11-15 at 7:52 p.m., she indicated she was in a hurry to provide care to a resident and failed to close the log.</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration.</p> <p>On 2-12-15 at 2:23 p.m., the DNS provided a copy of a document entitled, "HIPAA [Health Insurance Portability and Accountability Act] General</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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F 241 SS=D Bldg. 00	<p>Orientation Training for Frontline Staff." She indicated this document is provided to staff during orientation. The document indicated, "What is Confidential: All information about residents is considered private or 'confidential.', whether on paper, faxed. saved on a computer, spoken aloud. Includes their name, address, age, social security number, reason is at facility, treatments and medications they receive, caregivers' notes, and past history..."</p> <p>This Federal tag relates to Complaint IN00163746.</p> <p>3.1-3(o)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 4 residents reviewed for incontinence care was able to have their dignity maintained in that the resident felt as if she did not count as she was not included in conversation by the staff during care. (Resident #D)</p>	F 241	<p>F241</p> <p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Resident #D followed up on by SocialServices to assess for any negative psychosocial effects.</p> <p>How other residents having</p>	03/13/2015

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	<p>Findings include:</p> <p>On 2-10-15 at 2:35 p.m., the clinical record of Resident #D was reviewed. Her diagnoses included, but were not limited to, generalized pain, osteoarthritis, bilateral edema (swelling) of the lower extremities and muscle atrophy. Her most recent Minimum Data Set (MDS) assessment, dated 11-13-14, indicated she was moderately cognitively intact. It indicated she required extensive assistance of 2 or more persons for toileting needs, bed mobility, does not ambulate, requires the use of a wheelchair for mobility and is usually incontinent of bowel and bladder. During the initial tour of the facility on 2-10-15 with LPN #1, she was identified as alert and oriented to person, place and time.</p> <p>In an interview with Resident #D on 2-11-15 at 1:57 p.m., she indicated she due to her arthritis and urinary incontinence, she requires 2 staff members to assist her with care. "Sometimes I feel like I'm hardly here when they are working on me. The girls will talk to themselves [each other] right over me. About money, having to work, boyfriends. Things that are none of my business. Once in a while they might talk</p>		<p>thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?</p> <p>All residents have the potential to beaffected. Social Services interviewedrandom sample of alert and oriented residents to identify any residents withconcern regarding staff conversations not including them in the discussionduring care and staff treating residents with dignity.</p> <p>What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot reoccur?</p> <p>Nursing staff re-educated by 3/13/15 onResident Rights and Dignity and ensuring that resident is included in conversationduring care. Daily Rounds by NurseManagement Team / Weekend Nurse Manager to monitor for Resident Rights andDignity being upheld by staff including residents in appropriate conversationduring care. With permission ED willattend resident council meeting to promote opportunity for residents with concernsregarding not being treated with dignity and respect to voice those concerns.</p> <p>How will the corrective actions bemonitored to ensure they do not occur again?</p> <p>A ResidentRights / Dignity CQI monitoring tool will be completed by the DNS or designeeweekly x 6 weeks and monthly x 6 months to</p>		

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F 246 SS=D Bldg. 00	<p>to me, but it makes me feel like I don't count."</p> <p>On 2-10-15 at 11:25 a.m., the Director of Nursing Services provided a copy of the a policy entitled, "Resident Rights," with a revision date of 1/2006. This policy was identified as the current policy utilized by the facility. This policy indicated, "All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well-being, and proper delivery of care."</p> <p>This Federal tag relates to Complaint IN00163746.</p> <p>3.1-3(t)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on interview and record review, the facility failed to properly maintain a mattress for 1 of 4 residents reviewed for pain control, in a sample of 7, in a manner that did not contribute to pain and discomfort for a resident with recent</p>	F 246	<p>monitor for Resident Rights and Dignity being upheld by staff including residents in appropriate conversation during care. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p> <p>F246 What corrective action will take place for those residents found to be affected by the deficient practice? Resident #A mattress was replaced. How other residents having</p>	03/13/2015

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	<p>back surgery. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 2-10-15 at 2:15 p.m. Her diagnoses included, but were not limited to, kyphoplasty and spinal fusion surgery in January 2015, advanced age, osteoporosis and idiopathic neuropathy. The admission nursing assessment, dated 1-23-15, indicated she was cognitively intact with moderate pain of the back and legs almost constantly. It indicated she transferred to an area extended care facility on 1-24-15.</p> <p>In an interview with a family member of Resident #A on 2-10-15 at 11:52 a.m., he indicated Resident #A was admitted to the facility following back surgery in January, 2015. He found her lying on an older style mattress the day after admission, several days after the back surgery, and in pain. He observed the mattress to have holes in the mattress where springs were wearing through the material.</p> <p>In an interview with the Medical Director/Attending Physician of Resident #A on 2-11-15 at 8:30 p.m., he indicated he spoke with the family member of the resident on 1-24-15 regarding the</p>		<p>thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?</p> <p>All residents have the potential to beaffected. Maintenance Director conducted100% audit of all mattresses to ensure they are properly maintained tocontribute to comfort of residents.</p> <p>What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot reoccur?</p> <p>DNS re-educated nursing staff by 3/13/15on monitoring mattresses to ensure properly maintained to contribute to comfortof residents and grievance policy to ensure resident and residentrepresentative concerns are addressed timely. Executive Director re-educated Maintenance Director, HousekeepingSupervisor, Admissions Director, and Nurse Management to ensure that newadmissions receive properly maintained mattress to contribute to comfort ofresident upon admission and that mattresses are reviewed quarterly to ensurecomfort of residents ongoing. DailyRounds by Nurse Management Team / Weekend Nurse Manager to monitor for mattressesproperly maintained to contribute to comfort of residents and grievances beingaddressed timely.</p> <p>How will the corrective actions</p>		

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	<p>mattress. He indicated he observed the mattress. "The mattress was in bad shape. I looked at it. Had metal springs kind of poking when you pushed on it. I don't think the mattress was fit for anyone, let alone somebody who just had back surgery. By the time I came in [to the facility], she had been switched to a different mattress. It would certainly contribute to back pain for anyone, let alone [for someone who had] a new back surgery."</p> <p>The Director of Nursing Services (DNS) provided a copy of a "Concern/Grievance Form," dated 1-24-15. It detailed a concern by a family member requesting a different mattress for Resident #A. It indicated the mattress was changed upon the DNS becoming aware of the request. A second "Concern/Grievance Form," dated 1-28-15, was provided and signed by the Administrator. It indicated the resident was admitted to the facility related to recent back surgery and the older-style spring mattress was uncomfortable for the resident. It indicated after this occurrence, all older-style spring mattresses had been thrown out.</p> <p>This Federal tag relates to Complaint IN00163746.</p>		<p>bemonitored to ensure they do not occur again?</p> <p>A Mattressand Grievance CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor for mattresses properly maintained to contribute to comfort and grievances being addressed timely. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>				

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F 282 SS=E Bldg. 00	<p>3.1-19(m)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure facility staff adhere to professional standards of care related to following physician orders for administration of medications, for 5 of 7 residents reviewed for care related issues, in a sample of 7. This deficient practice has the potential to adversely affect the appropriate care provided to the residents of the facility. (Resident #A, #B, #C, #D and #E)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 2-10-15 at 2:15 p.m. Her diagnoses included, but were not limited to, kyphoplasty and spinal fusion surgery in January 2015, osteoporosis and idiopathic neuropathy. The admission nursing assessment, dated 1-23-15, indicated she was cognitively intact with moderate pain of the back and legs almost constantly. It indicated she</p>	F 282	<p>F282</p> <p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Resident #A is no longer a resident of this facility. Resident #B is no longer a resident of this facility, however her remaining medications after discharge were properly disposed of and medication return form completed. Resident #C is no longer a resident of this facility. Resident #D medication had already been received and was being administered and is still being administered per physician order. Resident #E is no longer a resident of this facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>All residents have the potential to be affected by this deficient practice upon discharge or discontinuation of medications. DNS/Designee conducted audit of discharged</p>	03/13/2015			

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	<p>transferred to an area extended care facility on 1-24-15.</p> <p>Review of Resident #A's Medication Administration Record (MAR) indicated she had received doses of the physician ordered Norco 5/325 milligrams (mg) every 4 hours as needed for pain on 1-23-15 at 9:00 p.m., 1-24-15 at 2:00 a.m., 7:00 a.m., 11:00 a.m., and 3:00 p.m. The resident's narcotic administration log indicated the same information.</p> <p>Review of the narcotic administration log for Resident #A's Norco 5/325 mg indicated the last documented dose administered by facility staff was on 1-24-15 at 3:00 p.m. There was an absence of documentation of the disposition of the remaining 15 doses of the medication on the log or in the resident's clinical record. A faxed statement, dated 2-12-15, from the facility in which the resident was transferred, indicated 14 doses of Norco 5/325 mg were received upon admission on 1-24-15.</p> <p>In an interview with LPN #2 on 2-12-15 at 2:32 p.m., she indicated on 1-24-15, she was assisting the resident with a transfer to another extended care facility. She indicated it was a rather chaotic atmosphere, but she did offer the resident</p>		<p>residents to ensure orders were received and writtencorrectly regarding medications upon discharge and medication return formcompleted. DNS/Designee conducted anaudit of MAR to ensure residents received medications as prescribed. Nursing staff re-educated regarding properdischarge orders, proper completion of medication return/destruction procedures, five rights of medication procedure, PRN medication documentation procedure andEDK process.</p> <p>What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot reoccur?</p> <p>Nursing staff re-educated by 3/13/15regarding proper discharge orders, proper completion of medicationreturn/destruction procedures, five rights of medication procedure, PRNmedication documentation procedure and EDK process. Daily Rounds by Nurse Management Team /Weekend Nurse Manager to monitor MAR/TAR to ensure PRN medication documentationprocedure, five rights of medication and EDK processes are followed. DNS or Designee will review the dischargeorders to ensure the proper discharge orders were obtained and the medicationreturn/destruction procedure was followed.</p> <p>How will the corrective actions bemonitored to ensure they do not</p>	

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	<p>a dose of the Norco 5/325 mg immediately prior to her transfer to the other facility. She indicated she administered the narcotic "right before she left." She continued, "I meant to chart [document] it, but I didn't...I sent her other pills and eye drops" with the ambulance staff that were transporting the resident to the other facility. She recalled she did not request a physician's order for permission to forward the resident's medications to the other facility as she had been told in the change of shift report she was to send all of the resident's medications with her to the other facility. She indicated she did not document what medications or the quantity of those medications that were sent to the other facility.</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration. On 2-12-15 at 5:25 p.m., she provided a copy of a procedure entitled, "Medication Pass Procedure, Skills Validation," with a review date of 3/2013 and was identified as the current policy/procedure used by the facility. The DNS indicated this is the procedure and form used by the facility for skills</p>		<p>occur again? A DischargeOrder / Medication Return Destruction Procedure / PRN Documentation / FiveRights of Medication / EDK CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor MAR/TAR to ensure PRN medication documentation procedure, five rights of medication and EDK processes are followed as well as the discharge orders to ensure the proper discharge orders were obtained and the medication return/destruction procedure was followed. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>				

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	<p>validation of staff who administer medications. This procedure indicated, "Medications checked 3 times to verify order with the label...Refusal of medication--identified by circling the initial and document on back of MAR...Medication administration will be recorded on the MAR or TAR [Treatment Administration Record] after given..."</p> <p>The Nursing Drug Guide, Nursing 2014 Drug Handbook, copyright 2014, included information on the safe administration of medications. It indicated, traditionally, the nursing profession cited the five rights of medication administration. The authors suggested eight rights for safe medication administration as follows:</p> <ul style="list-style-type: none"> -the right medication. -the right patient. -the right dose. -the right time. -the right route. -the right reason. -the right response. -the right documentation. <p>On 2-12-15 at 10:2 a.m., the DNS provided a copy of a policy and procedure entitled, "Medication Errors." This procedure had a revision date of 1/2006 and was identified as the current policy/procedure used by the facility.</p>			

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	<p>This policy indicated, "It is the policy of this provider to ensure residents residing in the facility are free of medication errors." The procedure indicated, "When a suspected medication error is identified, the nurse will immediately assess the condition of the affected resident and notify the physician of the event...The responsible party/family will be notified of the error. The DNS will be notified of the error, resident condition. The charge nurse will correct findings contributing to the error (i.e. destroy/return discontinued meds, correcting transcription errors, etc.) to prevent further errors. The charge nurse will complete a medication error report, including a brief summary of findings. Documentation in the medical record will include physicians/family notification, type of error, and assessment of the resident..."</p> <p>On 2-12-15 at 10:20 a.m., the DNS provided a copy of a policy entitled, "17.0 Disposition of Medications When a Resident Is Discharged From the Facility." This policy had a revision date of 7/2011 and was identified as the current policy/procedure used by the facility. The purpose was identified as, "To establish a policy and procedure that meets federal and state requirements regarding the disposal of medications when a resident is discharged from the</p>			

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	<p>facility." The procedure identified the following steps to meet the purpose:</p> <p>"Upon discharge from the facility, the patient's drugs are to:</p> <ul style="list-style-type: none"> a) Be released with the patient, or b) Be returned to the pharmacy for credit/destruction, or c) Be destroyed by two licensed nursing personnel. <p>NOTE: If a medication has been billed to the resident's private pay account, resident's private insurance, Medicare D plan or Medicaid plan, the medication belongs to the resident...."</p> <p>"17.01 Medications Released to the Resident On Discharge:</p> <ul style="list-style-type: none"> -A medication may be released to the resident upon discharge only with a physician's order specifying which medications are to be released with/to the resident. - If controlled substances are to be sent with the resident on discharge the physician must specify. -If the physician orders a medication(s) to be released with the resident the charge nurse is responsible for making certain that the medication's label is complete and he/she must review the directions for use with the resident or the resident's responsible party. -The nurse will document in the clinical record and/or the 'Medication Release form:' 			

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	<p>-What medications were released, the strength, and the number of tablets/capsules, the directions for use, and the time of day the resident is to take the medications.</p> <p>-What the medication is used for, and possible side effects.</p> <p>-Who was given the instructions..."</p> <p>"17.02 Controlled Medications:</p> <p>-All narcotic [medications] must be accounted for.</p> <p>-The nurse will document the following on the corresponding narcotic control log:</p> <p>-Date.</p> <p>-Time.</p> <p>-Quantity of medication released to the resident.</p> <p>-Who received the medication."</p> <p>2. Resident #B's clinical record was reviewed on 2-12-15 at 11:35 a.m. It indicated her diagnoses included, but were not limited to, bladder cancer, history of breast cancer, ischemic heart disease, history of deep vein thrombosis (blood clots), diabetes and chronic pain. Her most recent Minimum Data Set (MDS) assessment, dated 12-24-14, indicated she was cognitively intact; required extensive assistance of 2 or more person with bed mobility and extensive assistance of one person with transfers from one surface to another; did</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>not ambulate; required the use of a wheelchair for mobility. It indicated she received pain medication on a regular, scheduled basis due to occasional bouts of moderate-level pain. It indicated Resident #B had transferred to an area hospital on 1-27-15 and had not returned to the facility.</p> <p>Review of the January, 2015 recapitulation orders for Resident #B included a physician order for Norco 5/325 milligrams (mg) daily at bedtime as needed for pain. Review of the corresponding narcotic administration log for this medication revealed documentation to indicate it had been administered to the resident 3 times in a 5 week period, at a time other than bedtime. Those administration times were indicated to be 12-17-14 at 5:00 a.m., 1-3-15 at 5:00 a.m., and 1-22-15 at 5:30 a.m. This signature of the staff person providing each of the 3 administrations was LPN #3. Documentation for the reason of administering or the effectiveness of the "as needed" medication were absent. On 1-23-15 at 9:00 p.m., the Norco dosage was documented as provided twice on the narcotic administration log. The signatures, although of poor penmanship and difficult to read, appeared to be of two separate staff members.</p>			

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	<p>Review of Resident #B's "Medication Return Form" or the medication disposition record (form used to reconcile all medications sent with residents, destroyed by the facility or returned to the ordering pharmacy upon transfer or discharge of a resident) indicated 6 medications were unaccounted for on the form. Those physician ordered medications were as follows:</p> <ul style="list-style-type: none"> -UTI-Stat 30 milliliters daily by mouth. -MI Acid Suspension 30 milliliters every 4 hours as needed [for indigestion]. -Milk of Magnesia 30 milliliters daily as needed [for constipation]. -acetaminophen 325 mg 2 tablets every 4 hours as needed for pain. -nitroglycerin 0.4 mg SL (under the tongue) every 5 minutes up to 3 times as needed for chest pain. -guaifenisin SA 10 milliliters every 4 hours as needed for cough. <p>On 2-12-15 at 4:30 p.m., the Director of Nursing Services located 3 containers of medications, specifically, those for UTI-Stat, MI Acid Suspension and guaifenisin SA. In interview at this time, she indicated those bottles, each labeled with the name of Resident #B and the directions for use, had been found in the facility. She indicated she had no idea why those medications were still in the</p>			

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	<p>building and had not been returned to the pharmacy or appropriately destroyed, according to the facility's policies.</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration. On 2-12-15 at 5:25 p.m., she provided a copy of a procedure entitled, "Medication Pass Procedure, Skills Validation," with a review date of 3/2013 and was identified as the current policy/procedure used by the facility. The DNS indicated this is the procedure and form used by the facility for skills validation of staff who administer medications. This procedure indicated, "Medications checked 3 times to verify order with the label...Refusal of medication--identified by circling the initial and document on back of MAR...Medication administration will be recorded on the MAR or TAR [Treatment Administration Record] after given..."</p> <p>The Nursing Drug Guide, Nursing 2014 Drug Handbook, copyright 2014, included information on the safe administration of medications. It indicated, traditionally, the nursing professions cited the five rights of</p>			

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	<p>medication administration. The authors suggested eight rights for safe medication administration as follows:</p> <ul style="list-style-type: none"> -the right medication. -the right patient. -the right dose. -the right time. -the right route. -the right reason. -the right response. -the right documentation. <p>On 2-12-15 at 10:2 a.m., the DNS provided a copy of a policy and procedure entitled, "Medication Errors." This procedure had a revision date of 1/2006 and was identified as the current policy/procedure used by the facility. This policy indicated, "It is the policy of this provider to ensure residents residing in the facility are free of medication errors." The procedure indicated, "When a suspected medication error is identified, the nurse will immediately assess the condition of the affected resident and notify the physician of the event...The responsible party/family will be notified of the error. The DNS will be notified of the error, resident condition. The charge nurse will correct findings contributing to the error (i.e. destroy/return discontinued meds, correcting transcription errors, etc.) to prevent further errors. The charge nurse will complete a medication error</p>			

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	<p>report, including a brief summary of findings. Documentation in the medical record will include physicians/family notification, type of error, and assessment of the resident..."</p> <p>On 2-12-15 at 10:20 a.m., the DNS provided a copy of a policy entitled, "17.0 Disposition of Medications When a Resident Is Discharged From the Facility." This policy had a revision date of 7/2011 and was identified as the current policy/procedure used by the facility. The purpose was identified as, "To establish a policy and procedure that meets federal and state requirements regarding the disposal of medications when a resident is discharged from the facility." The procedure identified the following steps to meet the purpose: "Upon discharge from the facility, the patient's drugs are to: a) Be released with the patient, or b) Be returned to the pharmacy for credit/destruction, or c) Be destroyed by two licensed nursing personnel.</p> <p>3. The clinical record of Resident #C was reviewed on 2-11-15 at 3:30 p.m. Her diagnoses included, but were not limited to, end-stage dementia with hospice services.</p>			

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	<p>Review of the nursing progress notes indicated on 12-13-14 at 9:14 p.m., Resident #C's temperature (axillary or under the arm) was quite elevated at 103.3 degrees F (Fahrenheit). The notes, signed by LPN #4, indicated due to the resident being unresponsive, she was unsuccessful in her attempts to administer oral Tylenol. She notified and received orders from the hospice services for Tylenol suppository in which one could be administered every 8 hours as needed for increased temperature. The progress notes did not indicate if or when this medication was administered.</p> <p>Review of the Medication Administration Record (MAR) indicated the order had been transcribed onto the MAR and the staff member's initials were documented on a block for the date of 12-13-14, but without a corresponding time of administration. In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 3:40 p.m., she indicated she spoke with LPN #4 regarding this issue. She indicated LPN #4 recalled administering the medication immediately upon receipt of the order, as she obtained the medication from the EDK (Emergency Drug Kit). However, she recalled she did not fill out a slip for this medication from the EDK. The DNS further explained the facility does not have documentation, such as a written</p>			

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	<p>24-hour report form to indicate resident care issues, such as elevated temperatures and what treatments were conducted for those care issues. "So, basically, we have no paper trail" [to indicate the medication was given on 12-13-14.]</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration. On 2-12-15 at 5:25 p.m., she provided a copy of a procedure entitled, "Medication Pass Procedure, Skills Validation," with a review date of 3/2013 and was identified as the current policy/procedure used by the facility. The DNS indicated this is the procedure and form used by the facility for skills validation of staff who administer medications. This procedure indicated, "...Medication administration will be recorded on the MAR or TAR [Treatment Administration Record] after given..."</p> <p>The Nursing Drug Guide, Nursing 2014 Drug Handbook, copyright 2014, included information on the safe administration of medications. It indicated, traditionally, the nursing professions cited the five rights of medication administration. The authors</p>				

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	<p>suggested eight rights for safe medication administration as follows:</p> <ul style="list-style-type: none"> -the right medication. -the right patient. -the right dose. -the right time. -the right route. -the right reason. -the right response. -the right documentation. <p>On 2-12-15 at 10:2 a.m., the DNS provided a copy of a policy and procedure entitled, "Medication Errors." This procedure had a revision date of 1/2006 and was identified as the current policy/procedure used by the facility. This policy indicated, "It is the policy of this provider to ensure residents residing in the facility are free of medication errors." The procedure indicated, "When a suspected medication error is identified, the nurse will immediately assess the condition of the affected resident and notify the physician of the event...The responsible party/family will be notified of the error. The DNS will be notified of the error, resident condition. The charge nurse will correct findings contributing to the error (i.e. destroy/return discontinued meds, correcting transcription errors, etc.) to prevent further errors. The charge nurse will complete a medication error report, including a brief summary of</p>			

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	<p>findings. Documentation in the medical record will include physicians/family notification, type of error, and assessment of the resident..."</p> <p>4. On 2-10-15 at 2:35 p.m., the clinical record of Resident #D was reviewed. Her diagnoses included, but were not limited to, generalized pain, osteoarthritis, bilateral edema (swelling) of the lower extremities and muscle atrophy. Her most recent Minimum Data Set (MDS) assessment, dated 11-13-14, indicated she was moderately cognitively intact. She required extensive assistance of 2 or more persons for bed mobility, does not ambulate, requires the use of a wheelchair for mobility and received routinely scheduled pain medication. In an interview with LPN #1 on 2-10-15 at 11:00 a.m., during the initial tour of the facility, she identified Resident #D as being alert and oriented to person, place and time, as well as receiving routinely scheduled pain medication for generalized pain.</p> <p>In interview with Resident #D on 2-11-15 at 1:57 p.m., she indicated she experiences a great deal of arthritic pain of her knees and legs. She explained that she usually receives her pain medication every 4 hours, "but I think sometimes they [facility staff] forget [to administer]</p>			

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	<p>it."</p> <p>In review of the Medication Administration Record (MAR) for January, 2015 and the corresponding narcotic administration log for Resident #D, it indicated during the time period of 1-16-15 and 1-20-15, several doses could not clearly be ascertained as administered to the resident for the physician ordered medication of Norco 10/325 milligrams (mg) every 4 hours while awake. The administration times listed for this medication were 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m.</p> <p>The narcotic administration log is utilized to document each time a dose of the specific narcotic for a specific resident is taken from its corresponding package in order to keep a detailed record of the narcotic. The narcotic administration log for Resident #D's Norco 10/325 mg indicated the following:</p> <p>-1-16-15 at 6:00 a.m., was documented as administered.</p> <p>1-16-15 at 2:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m., had no information listed to acknowledge Resident #D received the ordered dose of Norco 10/325 mg.</p> <p>-1-16-15 at 10:00 p.m., an EDK (Emergency Drug Kit) acknowledgement</p>			

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	<p>slip indicated authorization was provided for one dose of Norco 10/325 mg to be provided to Resident #D.</p> <p>-1-17-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 10:00 p.m., were documented as administered. The 6:00 p.m., dose was not documented as administered.</p> <p>-1-18-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m., were documented as administered. The 10:00 p.m., dose was not documented as administered.</p> <p>-1-19-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m., were not documented as administered.</p> <p>-1-20-15 at 2:00 a.m., 6:00 a.m., and 10:00 a.m., were not documented as administered. The doses for 2:00 p.m., 6:00 p.m., and 10:00 p.m., were documented as administered.</p> <p>The corresponding MAR for January, 2015 for Resident #D contained many small boxes which made the document very difficult to read. The information for the physician ordered Norco 10/325 mg every 4 hours while awake indicated the following:</p> <p>1-16-15 at 2:00 a.m., the staff member's initials were listed in the appropriate box to indicate it had been administered to the resident. However, the narcotic</p>			

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	<p>administration record contained no information to acknowledge Resident #D received the ordered dose of Norco 10/325 mg.</p> <p>-1-16-15 at 6:00 a.m., a blank box, indicating a lack of the staff member's initials, thus indicating the medication was not administered to the resident.</p> <p>1-16-15 at 10:00 a.m., 2:00 p.m., and 6:00 p.m., encircled initials of the staff member were in the appropriate boxes. Encircled initials of the staff member indicates the medication was not provided to the resident.</p> <p>-1-16-15 at 10:00 p.m., an EDK (Emergency Drug Kit) acknowledgement slip indicated authorization was provided for one dose of Norco 10/325 mg to be provided to Resident #D.</p> <p>-1-17-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 10:00 p.m., were documented as administered. The 6:00 p.m., dose was not documented as administered.</p> <p>-1-18-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m., was documented as administered. The 10:00 p.m., dose was not documented as administered.</p> <p>-1-19-15 The medication was documented as administered at 2:00 a.m., 6:00 a.m., 10:00 a.m., and 2:00 p.m. The medication was documented as not administered at 6:00 p.m., and 10:00 p.m.</p>			

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	<p>-1-20-15 at 6:00 a.m., a blank box, indicating the medication was not provided to the resident.</p> <p>-1-20-15 at 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m., doses were documented as administered.</p> <p>The back side of the MAR is typically utilized by staff to explain, in narrative form, a detailed accounting of why an "as needed" medication was provided or why a routinely ordered medication was not provided to a resident. The back sides of the MAR for January, 2015 were blank in regard to the Norco 10/325 mg.</p> <p>Additionally, documentation in Resident #D's clinical record did not indicate any issues related to the resident not receiving the Norco 10/325 mg as ordered, nor did it indicate Resident #D's attending physician or the resident were notified of the multiple doses of the medication being unavailable or not administered.</p> <p>On 2-11-15 at 3:05 p.m., the narcotic administration log for February, 2015 for Resident #D's Norco 10/325 mg was observed with LPN #4. The 2-11-15 dose for 2:00 p.m., was not documented. When this absent entry was brought to the attention of LPN #4, she indicated, "Oh, I haven't signed that out yet." LPN #4 was then observed to document the narcotic as being administered on</p>			

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	<p>2-11-15 at 2:00 p.m. She continued speaking as she turned pages in the narcotic administration log, "Well, I forgot to do several. I know we're supposed to do that at the time we give it." She was observed to document at least 2 other unknown residents's narcotic administrations at that time.</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration. On 2-12-15 at 5:25 p.m., she provided a copy of a procedure entitled, "Medication Pass Procedure, Skills Validation," with a review date of 3/2013 and was identified as the current policy/procedure used by the facility. The DNS indicated this is the procedure and form used by the facility for skills validation of staff who administer medications. This procedure indicated, "...Medication administration will be recorded on the MAR or TAR [Treatment Administration Record] after given..."</p> <p>The Nursing Drug Guide, Nursing 2014 Drug Handbook, copyright 2014, included information on the safe administration of medications. It indicated, traditionally, the nursing</p>			

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	<p>professions cited the five rights of medication administration. The authors suggested eight rights for safe medication administration as follows:</p> <ul style="list-style-type: none"> -the right medication. -the right patient. -the right dose. -the right time. -the right route. -the right reason. -the right response. -the right documentation. <p>On 2-12-15 at 10:2 a.m., the DNS provided a copy of a policy and procedure entitled, "Medication Errors." This procedure had a revision date of 1/2006 and was identified as the current policy/procedure used by the facility. This policy indicated, "It is the policy of this provider to ensure residents residing in the facility are free of medication errors." The procedure indicated, "When a suspected medication error is identified, the nurse will immediately assess the condition of the affected resident and notify the physician of the event...The responsible party/family will be notified of the error. The DNS will be notified of the error, resident condition. The charge nurse will correct findings contributing to the error (i.e. destroy/return discontinued meds, correcting transcription errors, etc.) to prevent further errors. The charge</p>			

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	<p>nurse will complete a medication error report, including a brief summary of findings. Documentation in the medical record will include physicians/family notification, type of error, and assessment of the resident..."</p> <p>5. The clinical record of Resident #E was reviewed on 2-12-15 at 11:45 a.m. It indicated her diagnoses include, but were not limited to, Alzheimer's disease and hypothermia related to an elopement from home in January, 2015. It indicated discharge to home with family was planned for 1-23-15.</p> <p>Review of the admission orders, dated 1-16-15, included, but were not limited to the following medications: -atenolol 25 milligrams (mg) each morning by mouth. -famotidine 20 mg twice daily by mouth. -aspirin 81 mg each morning by mouth. -multivitamin plus folic acid 400 micrograms daily by mouth. -mirtazapine 15 mg daily at bedtime by mouth as needed for insomnia. -Tylenol 325 mg every 4 hours by mouth as needed for pain. -Colace 100 mg daily at bedtime by mouth as needed for constipation -Zofran 4 mg every 6 hours by mouth as needed for nausea or vomiting.</p>			

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	<p>A physician's telephone order, dated 1-21-15, indicated the resident was to be discharged on Friday, 1-23-15. This telephone order did not specify if the resident's medications were to be sent with her upon discharge from the facility.</p> <p>A facility computerized "Observation Report" for "Home Discharge Instructions," dated 1-23-15 at 10:25 a.m., indicated under the heading of "Medication and Treatments" specified, "List all current medication and treatment orders. (Medication/Treatment, dose, frequency, reason for use, time of last administration, amount sent with and prescription number)" This section was completed by the facility with the following information: "ATENOLOL 25 mg one tablet by mouth every morning for high blood pressure. PEPCID 20 mg one tablet by mouth two times per day for GERD. ASPIRIN 81 mg one tablet my mouth every morning for heart. MULTIVITAMIN WITH FOLIC ACID one tablet by mouth daily as a supplement. MIRALAX 17 GM mixed in 8 ounces fluid by mouth daily for constipation. ENSURE daily. MIRTAZAPINE 15 mg one by mouth daily at bedtime as needed for insomnia. TYLENOL 325 mg one tablet by mouth</p>			

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	<p>every 4 hours by mouth as needed for pain or fever.</p> <p>COLACE 100 mg one capsule at bedtime as needed for constipation.</p> <p>ZOFRAN 4 mg one tablet by mouth every 6 hours as needed for nausea or vomiting.</p> <p>DULCOLAX SUPPOSITORY 10 mg one rectally daily as needed for constipation."</p> <p>The above list of medications did not include the quantity of each medication sent with the resident, nor did it include the prescription numbers of any of the the medications listed or the last administration time of each listed medication.</p> <p>A nursing note, dated 1-23-15 at 10:30 a.m., indicated, "Discharge instructions and medications discussed with family...All meds sent with family as well as copy of discharge instructions..."</p> <p>The Nursing Drug Guide, Nursing 2014 Drug Handbook, copyright 2014, included information on the safe administration of medications. It indicated, traditionally, the nursing professions cited the five rights of medication administration. The authors suggested eight rights for safe medication administration as follows:</p>			

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	<p>-the right medication. -the right patient. -the right dose. -the right time. -the right route. -the right reason. -the right response. -the right documentation.</p> <p>On 2-12-15 at 10:20 a.m., the DNS provided a copy of a policy entitled, "17.0 Disposition of Medications When a Resident Is Discharged From the Facility." This policy had a revision date of 7/2011 and was identified as the current policy/procedure used by the facility. The purpose was identified as, "To establish a policy and procedure that meets federal and state requirements regarding the disposal of medications when a resident is discharged from the facility." The procedure identified the following steps to meet the purpose: "Upon discharge from the facility, the patient's drugs are to: a) Be released with the patient, or b) Be returned to the pharmacy for credit/destruction, or c) Be destroyed by two licensed nursing personnel. NOTE: If a medication has been billed to the resident's private pay account, resident's private insurance, Medicare D plan or Medicaid plan, the medication</p>			

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	<p>belongs to the resident...."</p> <p>"17.01 Medications Released to the Resident On Discharge:</p> <ul style="list-style-type: none"> -A medication may be released to the resident upon discharge only with a physician's order specifying which medications are to be released with/to the resident. - If controlled substances are to be sent with the resident on discharge the physician must specify. -If the physician orders a medication(s) to be released with the resident the charge nurse is responsible for making certain that the medication's label is complete and he/she must review the directions for use with the resident or the resident's responsible party. -The nurse will document in the clinical record and/or the 'Medication Release form:' -What medications were released, the strength, and the number of tablets/capsules, the directions for use, and the time of day the resident is to take the medications. -What the medication is used for, and possible side effects. -Who was given the instructions..." <p>"17.02 Controlled Medications:</p> <ul style="list-style-type: none"> -All narcotic [medications] must be accounted for. -The nurse will document the following 			

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F 441 SS=E Bldg. 00	<p>on the corresponding narcotic control log: -Date. -Time. -Quantity of medication released to the resident. -Who received the medication."</p> <p>This Federal tag relates to Complaint IN00163746 and Complaint IN00164122.</p> <p>3.1-35(g)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with</p>			

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	<p>a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure the clean linen carts utilized in 1 of 4 halls during 1 of 4 observations did not hold items other than clean linens for the use of the residents. This deficiency has the potential to adversely effect all 32 residents of C hall.</p> <p>Findings include:</p> <p>During a routine tour of the facility on 2-11-15 at 7:47 p.m. on Hall C, a clean linen cart was observed to contain clean bed linens, blankets, towels and wash clothes for the use of the residents of the hall. Additionally, on the top shelf, two large Styrofoam drink containers with lids and straws were observed. Both cups were identifiable as products from local service stations, one identified as containing 32 ounces of liquid and the other did not specify the amount of liquid</p>	F 441	<p>F441</p> <p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>C Hall Residents had the potential to be affected. Drink cups and notebooks were removed from the linen cart and the linen cart cover was reapplied to ensure the items were not easily accessible and covered.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>All residents on C Hall had the potential to be affected. DNS conducted 100% audit of linen carts to ensure no drink cups or notebooks or other personal items were on the linen cart and the linen cart cover is keeping items covered and not easily accessible.</p> <p>What measures will be put into place or what systemic changes will</p>	03/13/2015

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	<p>the cup contained. A clipboard was observed on the top shelf, as well, with multiple pages of unknown information. The cover for the clean linen cart was observed to be flipped over the top of the linen cart, resulting in all of the linen stored on the cart being exposed and easily accessible to anyone passing by the cart.</p> <p>In an interview with the Administrator on 2-12-15 at 9:40 a.m., he indicated he had observed one large drink cup and a clipboard located on the C hall of the facility the evening before. He indicated, "That should not be there." He indicated the facility administrative staff have spoken with the facility staff that the clean linen cart is only for clean linens, not storage of other items.</p> <p>On 2-12-15 at 5:25 p.m., the DNS provided a copy of policy entitled, "Laundry/Linen," with a review date of 2/2012. This policy was identified as the current policy utilized by the facility. It indicated, " Policy: The laundry staff shall handle, store, process, and transport linen appropriately to prevent the spread of infection, in resident-care areas and in the laundry facility. Purpose: To ensure the proper care of linen and laundry to prevent the spread of infection...</p> <p>2. Resident care areas: Clean linen</p>		<p>be made to ensure that the deficient practice doesnot reoccur?</p> <p>Nursing staff re-educated by 3/13/15 onLinen Cart Storage. Daily Rounds byNurse Management Team / Weekend Nurse Manager to monitor to ensure no drinkcups or notebooks or other personal items are on the linen cart and the linencart cover is keeping items covered and not easily accessible.</p> <p>How will the corrective actions bemonitored to ensure they do not occur again?</p> <p>A Linen Cart Storage CQI monitoringtool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6months to monitor to ensure no drink cups or notebooks or other personal itemsare on the linen cart and the linen cart cover is keeping items covered and noteasily accessible. Audit tools will besubmitted to the CQI committee and action plans will be developed as needed ifthe threshold of 100% is not met.</p>		

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F 514 SS=E Bldg. 00	<p>a. Clean linen must be protected from soiling or contamination.</p> <p>i. Clean linen should be carried away from the body to prevent contamination.</p> <p>ii. Carts/racks must be covered..."</p> <p>This Federal tag relates to Complaint IN00163746.</p> <p>3.1-18(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to ensure facility staff routinely document the care provided to residents, for 5 of 5 residents reviewed for care related issues, in a sample of 7. This deficient practice has the potential to adversely affect the appropriate care provided to the residents</p>	F 514	<p>F514 What corrective action will take place for those residents found to be affected by the deficient practice? Resident #A is no longer a resident of this facility. Resident #B is no longer a resident of this facility, however her remaining medications</p>	03/13/2015

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	<p>of the facility. (Resident #A, #B, #C, #D and #E)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 2-10-15 at 2:15 p.m. Her diagnoses included, but were not limited to, kyphoplasty and spinal fusion surgery in January 2015, osteoporosis and idiopathic neuropathy. The admission nursing assessment, dated 1-23-15, indicated she was cognitively intact with moderate pain of the back and legs almost constantly. It indicated she transferred to an area extended care facility on 1-24-15.</p> <p>Review of Resident #A's Medication Administration Record (MAR) indicated she had received doses of the physician ordered Norco 5/325 milligrams (mg) every 4 hours as needed for pain on 1-23-15 at 9:00 p.m., 1-24-15 at 2:00 a.m., 7:00 a.m., 11:00 a.m., and 3:00 p.m. The resident's narcotic administration log indicated the same information.</p> <p>Review of the narcotic administration log for Resident #A's Norco 5/325 mg indicated the last documented dose administered by facility staff was on 1-24-15 at 3:00 p.m. There was an absence of documentation of the</p>		<p>after discharge were properly disposed of and medication return form completed. Resident #C is no longer a resident of this facility. Resident #D medication had already been received and was being administered and is still being administered. Resident #E is no longer a resident of this facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>All residents have the potential to be affected by this deficient practice upon discharge or discontinuation of medications. DNS conducted audit of discharged residents to ensure orders were received and written correctly regarding medications upon discharge and medication return form completed. DNS/Designee conducted an audit of MAR to ensure residents received medications as prescribed. Nursing staff re-educated regarding proper discharge orders, proper completion of medication return/destruction procedures, five rights of medication procedure, PRN medication documentation procedure and EDK process.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Nursing staff re-educated by 3/13/15 regarding proper discharge orders, proper completion of</p>	

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	<p>disposition of the remaining 15 doses of the medication on the log or in the resident's clinical record. A faxed statement, dated 2-12-15, from the facility in which the resident was transferred, indicated 14 doses of Norco 5/325 mg were received upon admission on 1-24-15.</p> <p>In an interview with LPN #2 on 2-12-15 at 2:32 p.m., she indicated on 1-24-15, she was assisting the resident with a transfer to another extended care facility. She indicated it was a rather chaotic atmosphere, but she did offer the resident a dose of the Norco 5/325 mg immediately prior to her transfer to the other facility. She indicated she administered the narcotic "right before she left." She continued, "I meant to chart [document] it, but I didn't...I sent her other pills and eye drops" with the ambulance staff that were transporting the resident to the other facility. She recalled she did not request a physician's order for permission to forward the resident's medications to the other facility as she had been told in the change of shift report she was to send all of the resident's medications with her to the other facility. She indicated she did not document what medications or the quantity of those medications that were sent to the other facility.</p>		<p>medication return/destruction procedures, five rights of medication procedure, PRN medication documentation procedure and EDK process. Daily Rounds by Nurse Management Team / Weekend Nurse Manager to monitor MAR/TAR to ensure PRN medication documentation procedure, five rights of medication and EDK processes are followed. DNS or Designee will review the discharge orders to ensure the proper discharge orders were obtained and the medication return/destruction procedure was followed.</p> <p>How will the corrective actions be monitored to ensure they do not occur again?</p> <p>A Discharge Order / Medication Return Destruction Procedure / PRN Documentation / Five Rights of Medication / EDK CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor MAR/TAR to ensure PRN medication documentation procedure, five rights of medication and EDK processes are followed as well as the discharge orders to ensure the proper discharge orders were obtained and the medication return/destruction procedure was followed. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>	

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	<p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration.</p> <p>On 2-12-15 at 5:25 p.m., she provided a copy of a procedure entitled, "Medication Pass Procedure, Skills Validation," with a review date of 3/2013 and was identified as the current policy/procedure used by the facility. The DNS indicated this is the procedure and form used by the facility for skills validation of staff who administer medications. This procedure indicated, "...Refusal of medication-identified by circling the initial and document on back of MAR...Medication administration will be recorded on the MAR or TAR [Treatment Administration Record] after given..."</p> <p>On 2-12-15 at 10:2 a.m., the DNS provided a copy of a policy and procedure entitled, "Medication Errors." This procedure had a revision date of 1/2006 and was identified as the current policy/procedure used by the facility. This policy indicated, "It is the policy of this provider to ensure residents residing in the facility are free of medication</p>			

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	<p>errors." The procedure indicated, "When a suspected medication error is identified, the nurse will immediately assess the condition of the affected resident and notify the physician of the event...The responsible party/family will be notified of the error. The DNS will be notified of the error, resident condition. The charge nurse will correct findings contributing to the error (i.e. destroy/return discontinued meds, correcting transcription errors, etc.) to prevent further errors. The charge nurse will complete a medication error report, including a brief summary of findings. Documentation in the medical record will include physicians/family notification, type of error, and assessment of the resident..."</p> <p>On 2-12-15 at 10:20 a.m., the DNS provided a copy of a policy entitled, "17.0 Disposition of Medications When a Resident Is Discharged From the Facility." This policy had a revision date of 7/2011 and was identified as the current policy/procedure used by the facility. The purpose was identified as, "To establish a policy and procedure that meets federal and state requirements regarding the disposal of medications when a resident is discharged from the facility." The procedure identified the following steps to meet the purpose: "Upon discharge from the facility, the</p>			

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	<p>patient's drugs are to:</p> <ul style="list-style-type: none"> a) Be released with the patient, or b) Be returned to the pharmacy for credit/destruction, or c) Be destroyed by two licensed nursing personnel. <p>NOTE: If a medication has been billed to the resident's private pay account, resident's private insurance, Medicare D plan or Medicaid plan, the medication belongs to the resident...."</p> <p>"17.01 Medications Released to the Resident On Discharge:</p> <ul style="list-style-type: none"> -A medication may be released to the resident upon discharge only with a physician's order specifying which medications are to be released with/to the resident. - If controlled substances are to be sent with the resident on discharge the physician must specify. -If the physician orders a medication(s) to be released with the resident the charge nurse is responsible for making certain that the medication's label is complete and he/she must review the directions for use with the resident or the resident's responsible party. -The nurse will document in the clinical record and/or the 'Medication Release form:' -What medications were released, the strength, and the number of tablets/capsules, the directions for use, 			

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	<p>and the time of day the resident is to take the medications.</p> <ul style="list-style-type: none"> -What the medication is used for, and possible side effects. -Who was given the instructions..." <p>"17.02 Controlled Medications:</p> <ul style="list-style-type: none"> -All narcotic [medications] must be accounted for. -The nurse will document the following on the corresponding narcotic control log: <ul style="list-style-type: none"> -Date. -Time. -Quantity of medication released to the resident. -Who received the medication." <p>The Nursing Drug Guide, Nursing 2014 Drug Handbook, copyright 2014, included information on the safe administration of medications. It indicated, traditionally, the nursing professions cited the five rights of medication administration. The authors suggested eight rights for safe medication administration as follows:</p> <ul style="list-style-type: none"> -the right medication. -the right patient. -the right dose. -the right time. -the right route. -the right reason. -the right response. -the right documentation. 			

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	<p>2. Resident #B's clinical record was reviewed on 2-12-15 at 11:35 a.m. It indicated her diagnoses included, but were not limited to, bladder cancer, history of breast cancer, ischemic heart disease, history of deep vein thrombosis (blood clots), diabetes and chronic pain. Her most recent Minimum Data Set (MDS) assessment, dated 12-24-14, indicated she was cognitively intact; required extensive assistance of 2 or more person with bed mobility and extensive assistance of one person with transfers from one surface to another; did not ambulate; required the use of a wheelchair for mobility. It indicated she received pain medication on a regular, scheduled basis due to occasional bouts of moderate-level pain. It indicated Resident #B had transferred to an area hospital on 1-27-15 and had not returned to the facility.</p> <p>Review of the January, 2015 recapitulation orders for Resident #B included a physician order for Norco 5/325 milligrams (mg) daily at bedtime as needed for pain. Review of the corresponding narcotic administration log for this medication revealed documentation to indicate it had been administered to the resident 3 times in a 5</p>			

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	<p>week period, at a time other than bedtime. Those administration times were indicated to be 12-17-14 at 5:00 a.m., 1-3-15 at 5:00 a.m., and 1-22-15 at 5:30 a.m. The signature of the staff person providing each of the 3 doses was LPN #3. Documentation for the reason the medication was provided or the effectiveness of the "as needed" medication were absent. On 1-23-15 at 9:00 p.m., the Norco dosage was documented as provided twice on the narcotic administration log. The signatures, although of poor penmanship and difficult to read, appeared to be of two separate staff members.</p> <p>Review of Resident #B's "Medication Return Form" or the medication disposition record (form used to reconcile all medications sent with residents, destroyed by the facility or returned to the ordering pharmacy upon transfer or discharge of a resident) indicated 6 medications were unaccounted for on the form. Those physician ordered medications were as follows:</p> <ul style="list-style-type: none"> -UTI-Stat 30 milliliters daily by mouth. -MI Acid Suspension 30 milliliters every 4 hours as needed [for indigestion]. -Milk of Magnesia 30 milliliters daily as needed [for constipation]. -acetaminophen 325 mg 2 tablets every 4 hours as needed for pain. 			

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	<p>-nitroglycerin 0.4 mg SL (under the tongue) every 5 minutes up to 3 times as needed for chest pain.</p> <p>-guaifenisin SA 10 milliliters every 4 hours as needed for cough.</p> <p>On 2-12-15 at 4:30 p.m., the Director of Nursing Services located 3 containers of medications, specifically, those for UTI-Stat, MI Acid Suspension and guaifenisin SA. In interview at this time, she indicated those bottles, each labeled with the name of Resident #B and the directions for use, had been found in the facility. She indicated she had no idea why those medications were still in the building and had not been returned to the pharmacy or appropriately destroyed, according to the facility's policies.</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration.</p> <p>On 2-12-15 at 5:25 p.m., she provided a copy of a procedure entitled, "Medication Pass Procedure, Skills Validation," with a review date of 3/2013 and was identified as the current policy/procedure used by the facility. The DNS indicated this is</p>			

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	<p>the procedure and form used by the facility for skills validation of staff who administer medications. This procedure indicated, "Medications checked 3 times to verify order with the label...Medication administration will be recorded on the MAR or TAR [Treatment Administration Record] after given..."</p> <p>On 2-12-15 at 10:2 a.m., the DNS provided a copy of a policy and procedure entitled, "Medication Errors." This procedure had a revision date of 1/2006 and was identified as the current policy/procedure used by the facility. This policy indicated, "It is the policy of this provider to ensure residents residing in the facility are free of medication errors." The procedure indicated, "When a suspected medication error is identified, the nurse will immediately assess the condition of the affected resident and notify the physician of the event...The responsible party/family will be notified of the error. The DNS will be notified of the error, resident condition. The charge nurse will correct findings contributing to the error (i.e. destroy/return discontinued meds, correcting transcription errors, etc.) to prevent further errors. The charge nurse will complete a medication error report, including a brief summary of findings. Documentation in the medical record will include physicians/family</p>			

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	<p>notification, type of error, and assessment of the resident..."</p> <p>On 2-12-15 at 10:20 a.m., the DNS provided a copy of a policy entitled, "17.0 Disposition of Medications When a Resident Is Discharged From the Facility." This policy had a revision date of 7/2011 and was identified as the current policy/procedure used by the facility. The purpose was identified as, "To establish a policy and procedure that meets federal and state requirements regarding the disposal of medications when a resident is discharged from the facility." The procedure identified the following steps to meet the purpose: "Upon discharge from the facility, the patient's drugs are to: a) Be released with the patient, or b) Be returned to the pharmacy for credit/destruction, or c) Be destroyed by two licensed nursing personnel.</p> <p>The Nursing Drug Guide, Nursing 2014 Drug Handbook, copyright 2014, included information on the safe administration of medications. It indicated, traditionally, the nursing professions cited the five rights of medication administration. The authors suggested eight rights for safe medication administration as follows:</p>			

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	<p>-the right medication. -the right patient. -the right dose. -the right time. -the right route. -the right reason. -the right response. -the right documentation.</p> <p>3. The clinical record of Resident #C was reviewed on 2-11-15 at 3:30 p.m. Her diagnoses included, but were not limited to, end-stage dementia with hospice services.</p> <p>Review of the nursing progress notes indicated on 12-13-14 at 9:14 p.m., Resident #C's temperature (axillary or under the arm) was quite elevated at 103.3 degrees F (Fahrenheit). The notes, signed by LPN #4, indicated due to the resident being unresponsive, she was unsuccessful in her attempts to administer oral Tylenol. She notified and received orders from the hospice services for Tylenol suppository in which one could be given to the resident every 8 hours as needed for increased temperature. The progress notes did not indicate if or when this medication was administered. Review of the Medication Administration Record (MAR) indicated the order had been transcribed onto the MAR and the staff member's initials were</p>			

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	<p>documented on a block for the date of 12-13-14, but without a corresponding time of administration. In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 3:40 p.m., she indicated she spoke with LPN #4 regarding this issue. She indicated she recalled administering the medication immediately upon receipt of the order, as she obtained the medication from the EDK (Emergency Drug Kit). However, she recalled she did not fill out a slip for this medication from the EDK. The DNS further explained the facility does not have documentation, such as a written 24-hour report form to indicate resident care issues, such as elevated temperatures and what treatments were conducted for those care issues. "So, basically, we have no paper trail" [to indicate the medication was given on 12-13-14.]</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration.</p> <p>On 2-12-15 at 5:25 p.m., she provided a copy of a procedure entitled, "Medication Pass Procedure, Skills Validation," with a review date of 3/2013 and was identified</p>			

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	<p>as the current policy/procedure used by the facility. The DNS indicated this is the procedure and form used by the facility for skills validation of staff who administer medications. This procedure indicated, "...Medication administration will be recorded on the MAR or TAR [Treatment Administration Record] after given..."</p> <p>The Nursing Drug Guide, Nursing 2014 Drug Handbook, copyright 2014, included information on the safe administration of medications. It indicated, traditionally, the nursing professions cited the five rights of medication administration. The authors suggested eight rights for safe medication administration as follows:</p> <ul style="list-style-type: none"> -the right medication. -the right patient. -the right dose. -the right time. -the right route. -the right reason. -the right response. -the right documentation. <p>4. On 2-10-15 at 2:35 p.m., the clinical record of Resident #D was reviewed. Her diagnoses included, but were not limited to, generalized pain, osteoarthritis, bilateral edema (swelling)</p>			

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	<p>of the lower extremities and muscle atrophy. Her most recent Minimum Data Set (MDS) assessment, dated 11-13-14, indicated she was moderately cognitively intact. It indicated she required extensive assistance of 2 or more persons for bed mobility, does not ambulate, requires the use of a wheelchair for mobility and received routinely scheduled pain medication. In interview with LPN #1 on 2-10-15 at 11:00 a.m., during the initial tour of the facility, she identified Resident #D as being alert and oriented to person, place and time, as well as receiving routinely scheduled pain medication for generalized pain.</p> <p>In an interview with Resident #D on 2-11-15 at 1:57 p.m., she indicated she experiences a great deal of arthritic pain of her knees and legs. She explained that she usually receives her pain medication every 4 hours, "but I think sometimes they [facility staff] forget [to administer] it."</p> <p>In review of the Medication Administration Record (MAR) for January, 2015 and the corresponding narcotic administration log for Resident #D, it indicated during the time period of 1-16-15 and 1-20-15, several doses could not clearly be ascertained as administered to the resident for the physician ordered</p>			

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	<p>medication of Norco 10/325 milligrams (mg) every 4 hours while awake. The administration times listed for this medication were documented as 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m.</p> <p>The narcotic administration log is utilized to document each time a dose of the specific narcotic for a specific resident is taken from its corresponding package in order to keep a detailed record of the narcotic. The narcotic administration log for Resident #D's Norco 10/325 mg indicated the following:</p> <p>-1-16-15 at 6:00 a.m., was documented as administered.</p> <p>1-16-15 at 2:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m., had no information listed to acknowledge Resident #D received the ordered dose of Norco 10/325 mg.</p> <p>-1-16-15 at 10:00 p.m., an EDK (Emergency Drug Kit) acknowledgement slip indicated authorization was provided for one dose of Norco 10/325 mg to be provided to Resident #D.</p> <p>-1-17-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 10:00 p.m., were documented as administered. The 6:00 p.m., dose was not documented as administered.</p> <p>-1-18-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m., were</p>			

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	<p>documented as administered. The 10:00 p.m., dose was not documented as administered.</p> <p>-1-19-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m., were not documented as administered.</p> <p>-1-20-15 at 2:00 a.m., 6:00 a.m., and 10:00 a.m., were not documented as administered. The doses for 2:00 p.m., 6:00 p.m., and 10:00 p.m., were documented as administered.</p> <p>The corresponding MAR for January, 2015 for Resident #D contained many small boxes which made the document very difficult to read. The information for the physician ordered Norco 10/325 mg every 4 hours while awake indicated the following:</p> <p>1-16-15 at 2:00 a.m., the staff members's initials were listed in the appropriate box to indicate it had been administered to the resident. However, the narcotic administration record contained no information to acknowledge Resident #D received the ordered dose of Norco 10/325 mg.</p> <p>-1-16-15 at 6:00 a.m., a blank box was present, thus indicating the medication was not administered to the resident.</p> <p>1-16-15 at 10:00 a.m., 2:00 p.m., and 6:00 p.m., encircled initials of the staff member were in the appropriate boxes.</p>			

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	<p>Encircled initials of a staff member indicates the medication was not provided to the resident.</p> <p>-1-16-15 at 10:00 p.m., an EDK (Emergency Drug Kit) acknowledgement slip indicated authorization was provided for one dose of Norco 10/325 mg to be provided to Resident #D.</p> <p>-1-17-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 10:00 p.m., were documented as administered. The 6:00 p.m., dose was not documented as administered.</p> <p>-1-18-15 at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m., were documented as administered. The 10:00 p.m., dose was not documented as administered.</p> <p>-1-19-15 The medication was documented as administered at 2:00 a.m., 6:00 a.m., 10:00 a.m., and 2:00 p.m. The medication was documented as not administered at 6:00 p.m. and 10:00 p.m.</p> <p>-1-20-15 at 6:00 a.m., a blank box was present</p> <p>-1-20-15 at 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m., doses were documented as administered.</p> <p>The back side of the MAR is typically utilized by staff to explain, in narrative form, a detailed accounting of why an "as needed" medication was provided or why a routinely ordered medication was not</p>			

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	<p>provided to a resident. The back sides of the MAR for January, 2015 were blank in regard to the Norco 10/325 mg. Additionally, documentation in Resident #D's clinical record did not indicate any issues related to the resident not receiving the Norco 10/325 mg as ordered, nor did it indicate Resident #D's attending physician or the resident were notified of the multiple doses of the medication being unavailable or not administered.</p> <p>On 2-11-15 at 3:05 p.m., the narcotic administration log for February, 2015 for Resident #D's Norco 10/325 mg was observed with LPN #4. The 2-11-15 dose for 2:00 p.m., was not observed to be documented. When this absent entry was brought to the attention of LPN #4, she indicated, "Oh, I haven't signed that out yet." LPN #4 was then observed to document the narcotic as being administered on 2-11-15 at 2:00 p.m. She continued speaking as she turned pages in the narcotic administration log, "Well, I forgot to do several. I know we're supposed to do that at the time we give it." She was observed to document at least 2 other unknown residents's narcotic administrations at that time.</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does</p>			

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	<p>not have a general medication administration policy beyond following the "Five Rights" of medication administration.</p> <p>On 2-12-15 at 5:25 p.m., she provided a copy of a procedure entitled, "Medication Pass Procedure, Skills Validation," with a review date of 3/2013 and was identified as the current policy/procedure used by the facility. The DNS indicated this is the procedure and form used by the facility for skills validation of staff who administer medications. This procedure indicated, "Medications checked 3 times to verify order with the label...Refusal of medication--identified by circling the initial and document on back of MAR...Medication administration will be recorded on the MAR or TAR [Treatment Administration Record] after given..."</p> <p>On 2-12-15 at 5:25 p.m., the DNS provided a copy of a procedure entitled, "Ordering Controlled/Scheduled II Medication." This procedure had a revision date of 7/2011 and was identified as the current policy/procedure used by the facility. This procedure indicated Schedule II medications require different ordering procedures than non-schedule medications. "The pharmacy is able to send Schedule II substances to the facility ONLY when the</p>			

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	<p>pharmacy has a valid prescription from the prescriber." Only in an emergency situation can the pharmacy send a Schedule II medication without having received a written/faxed prescription. In an emergency situation, up to a 72 hour supply of the medication can be provided to the facility for the resident. Schedule II prescriptions can be written for up to a 60 day supply. If an additional supply of the medication is required, the pharmacy will contact the physician to request a new written prescription.</p> <p>(This procedure continues into section 4.02 Scheduled II Medications:) "Please re-order all scheduled II medications a minimum of five (5) days before the resident will be out to allow the pharmacy ample time to contact the physician for the required prescription."</p> <p>On 2-12-15 at 10:2 a.m., the DNS provided a copy of a policy and procedure entitled, "Medication Errors." This procedure had a revision date of 1/2006 and was identified as the current policy/procedure used by the facility. This policy indicated, "It is the policy of this provider to ensure residents residing in the facility are free of medication errors." The procedure indicated, "When a suspected medication error is identified, the nurse will immediately assess the</p>			

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	<p>condition of the affected resident and notify the physician of the event...The responsible party/family will be notified of the error. The DNS will be notified of the error, resident condition. The charge nurse will correct findings contributing to the error (i.e. destroy/return discontinued meds, correcting transcription errors, etc.) to prevent further errors. The charge nurse will complete a medication error report, including a brief summary of findings. Documentation in the medical record will include physicians/family notification, type of error, and assessment of the resident..."</p> <p>The Nursing Drug Guide, Nursing 2014 Drug Handbook, copyright 2014, included information on the safe administration of medications. It indicated, traditionally, the nursing professions cited the five rights of medication administration. The authors suggested eight rights for safe medication administration as follows:</p> <ul style="list-style-type: none"> -the right medication. -the right patient. -the right dose. -the right time. -the right route. -the right reason. -the right response. -the right documentation. 			

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	<p>5. The clinical record of Resident #E was reviewed on 2-12-15 at 11:45 a.m. It indicated her diagnoses include, but were not limited to, Alzheimer's disease and hypothermia related to an elopement from home in January, 2015. It indicated discharge to home with family was planned for 1-23-15.</p> <p>Review of the admission orders, dated 1-16-15, included, but were not limited to the following medications: -atenolol 25 milligrams (mg) each morning by mouth. -famotidine 20 mg twice daily by mouth. -aspirin 81 mg each morning by mouth. -multivitamin plus folic acid 400 micrograms daily by mouth. -mirtazapine 15 mg daily at bedtime by mouth as needed for insomnia. -Tylenol 325 mg every 4 hours by mouth as needed for pain. -Colace 100 mg daily at bedtime by mouth as needed for constipation -Zofran 4 mg every 6 hours by mouth as needed for nausea or vomiting.</p> <p>A physician's telephone order, dated 1-21-15, indicated the resident was to be discharged on Friday, 1-23-15. This telephone order did not specify if the resident's medications were to be sent with her upon discharge from the facility.</p>				

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	<p>A facility computerized "Observation Report" for "Home Discharge Instructions," dated 1-23-15 at 10:25 a.m., indicated under the heading of "Medication and Treatments" specified, "List all current medication and treatment orders. (Medication/Treatment, dose, frequency, reason for use, time of last administration, amount sent with and prescription number)" This section was completed by the facility with the following information:</p> <p>"ATENOLOL 25 mg one tablet by mouth every morning for high blood pressure. PEPCID 20 mg one tablet by mouth two times per day for GERD. ASPIRIN 81 mg one tablet my mouth every morning for heart. MULTIVITAMIN WITH FOLIC ACID one tablet by mouth daily as a supplement. MIRALAX 17 GM mixed in 8 ounces fluid by mouth daily for constipation. ENSURE daily. MIRTAZAPINE 15 mg one by mouth daily at bedtime as needed for insomnia. TYLENOL 325 mg one tablet by mouth every 4 hours by mouth as needed for pain or fever. COLACE 100 mg one capsule at bedtime as needed for constipation. ZOFTRAN 4 mg one tablet by mouth every 6 hours as needed for nausea or vomiting.</p>			

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	<p>DULCOLAX SUPPOSITORY 10 mg one rectally daily as needed for constipation."</p> <p>The above list of medications did not include the quantity of each medication sent with the resident, nor did it include the prescription numbers of any of the the medications listed or the last administration time of each listed medication.</p> <p>A nursing note, dated 1-23-15 at 10:30 a.m., indicated, "Discharge instructions and medications discussed with family...All meds sent with family as well as copy of discharge instructions..."</p> <p>In an interview with the Director of Nursing Services (DNS) on 2-12-15 at 5:25 p.m., she indicated the facility does not have a general medication administration policy beyond following the "Five Rights" of medication administration.</p> <p>On 2-12-15 at 5:25 p.m., she provided a copy of a procedure entitled, "Medication Pass Procedure, Skills Validation," with a review date of 3/2013 and was identified as the current policy/procedure used by the facility. The DNS indicated this is the procedure and form used by the facility for skills validation of staff who</p>			

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	<p>administer medications. This procedure indicated, "Medications checked 3 times to verify order with the label...Refusal of medication--identified by circling the initial and document on back of MAR...Medication administration will be recorded on the MAR or TAR [Treatment Administration Record] after given..."</p> <p>On 2-12-15 at 10:2 a.m., the DNS provided a copy of a policy and procedure entitled, "Medication Errors." This procedure had a revision date of 1/2006 and was identified as the current policy/procedure used by the facility. This policy indicated, "It is the policy of this provider to ensure residents residing in the facility are free of medication errors." The procedure indicated, "When a suspected medication error is identified, the nurse will immediately assess the condition of the affected resident and notify the physician of the event...The responsible party/family will be notified of the error. The DNS will be notified of the error, resident condition. The charge nurse will correct findings contributing to the error (i.e. destroy/return discontinued meds, correcting transcription errors, etc.) to prevent further errors. The charge nurse will complete a medication error report, including a brief summary of findings. Documentation in the medical record will include physicians/family</p>			

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	<p>notification, type of error, and assessment of the resident..."</p> <p>On 2-12-15 at 10:20 a.m., the DNS provided a copy of a policy entitled, "17.0 Disposition of Medications When a Resident Is Discharged From the Facility." This policy had a revision date of 7/2011 and was identified as the current policy/procedure used by the facility. The purpose was identified as, "To establish a policy and procedure that meets federal and state requirements regarding the disposal of medications when a resident is discharged from the facility." The procedure identified the following steps to meet the purpose: "Upon discharge from the facility, the patient's drugs are to: a) Be released with the patient, or b) Be returned to the pharmacy for credit/destruction, or c) Be destroyed by two licensed nursing personnel. NOTE: If a medication has been billed to the resident's private pay account, resident's private insurance, Medicare D plan or Medicaid plan, the medication belongs to the resident...." "17.01 Medications Released to the Resident On Discharge: -A medication may be released to the resident upon discharge only with a</p>			

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	<p>physician's order specifying which medications are to be released with/to the resident.</p> <p>- If controlled substances are to be sent with the resident on discharge the physician must specify.</p> <p>-If the physician orders a medication(s) to be released with the resident the charge nurse is responsible for making certain that the medication's label is complete and he/she must review the directions for use with the resident or the resident's responsible party.</p> <p>-The nurse will document in the clinical record and/or the 'Medication Release form:'</p> <p>-What medications were released, the strength, and the number of tablets/capsules, the directions for use, and the time of day the resident is to take the medications.</p> <p>-What the medication is used for, and possible side effects.</p> <p>-Who was given the instructions..."</p> <p>"17.02 Controlled Medications:</p> <p>-All narcotic [medications] must be accounted for.</p> <p>-The nurse will document the following on the corresponding narcotic control log:</p> <p>-Date.</p> <p>-Time.</p> <p>-Quantity of medication released to the resident.</p> <p>-Who received the medication."</p>			

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	<p>The Nursing Drug Guide, Nursing 2014 Drug Handbook, copyright 2014, included information on the safe administration of medications. It indicated, traditionally, the nursing professions cited the five rights of medication administration. The authors suggested eight rights for safe medication administration as follows:</p> <ul style="list-style-type: none"> -the right medication. -the right patient. -the right dose. -the right time. -the right route. -the right reason. -the right response. -the right documentation. <p>This Federal tag relates to Complaint IN00163746 and Complaint IN00164122.</p> <p>3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3) 3.1-50(h)(5)(B) 3.1-50(h)(5)(C)</p>			