

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2013
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F000000	<p>This visit was for the PSR (Post Survey Revisit) to the Investigation of Complaint IN00138635 completed on 10/29/13.</p> <p>Complaint IN00138635 - Not Corrected.</p> <p>This visit was in conjunction with the PSR (Post Survey Revisit), to the PSR (Post Survey Revisit) to the Recertification and State Licensure Survey completed on 8/21/13.</p> <p>Survey dates: December 2, 3, 2013.</p> <p>Facility number: 000250 Provider number: 155359 AIM number: 100289980</p> <p>Survey team: Martha Saul RN, TC Sue Brooker, RD Virginia Terveer RN Julie Call RN</p> <p>Census bed type: SNF/NF: 43 Total: 43</p> <p>Census payor type: Medicare: 3 Medicaid: 37</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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	<p>Other: 3 Total: 43</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 6, 2013 by Randy Fry RN.</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician orders were followed for 3 residents (Resident #J, Resident #C, and Resident #D) of 3 residents reviewed for physician orders.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #J on 12/2/13 at 1:14 p.m., indicated the following: diagnoses included, but were not limited to: diabetes mellitus, pleural effusion, Stage II chronic kidney disease, hypertension, Cerebrovascular accident, multiple sclerosis, chronic depression, chronic psychosis, mood disorder, impulse control disorder, and muscle spasms.</p> <p>A Consultation Report for Resident #J, dated 11/22/13 and written by the Consultant Pharmacist, indicated she was receiving Lamictal 25 mg BID for mood disorder. The report</p>	F000282	<p>Please accept this Plan of Correction as our credible allegation of compliance. The Plan of Correction does not constitute an agreement by the provider of facts or conclusions set forth in this Statement of Deficiencies. The Plan of Correction is prepared solely because is required by Federal and State Law. F282Element #1</p> <p>The Primary Care Physician and Responsible Party for Resident #J were notified regarding the medication error on 11/29/13 and 12/1/13 by the Licensed Nurse on 12/02/13. Resident #J was assessed by the Director of Clinical Services (DCS)/Charge Nurse on 12/02/13 and suffered no apparent adverse effects from not receiving the medication on 11/29/13 and 12/1/13. The Licensed Nurse assigned to Resident #J on 11/29/13 is no longer employed at the facility. Resident C suffered no adverse effects from medication given on 11/22/13 and 11/25/13. The Primary Care Physician and Responsible Party for Resident # D was notified regarding the medication error on 11/21/13,</p>	12/17/2013	

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	<p>recommended a decrease in Lamictal to 25 mg daily for 1 month.</p> <p>A physician's order for Resident #J, dated 11/27/13, indicated to decrease Lamictal to 25 mg daily x (times) 1 month.</p> <p>A Daily Skilled Nurse's Note for Resident #J, dated 11/27/13, indicated a new order was received to decrease Lamictal to 25 mg daily x 1 month. The note also indicated she was notified and educated on the new order.</p> <p>The Medication Administration Record (MAR) for Resident #J, for the month of November, 2013, indicated the Lamictal was changed to 25 mg 1 x (time) daily x 1 month. The MAR also indicated she received the Lamictal 25 mg on 11/28/13 and on 11/30/13. There was no indication she received or refused the Lamictal 11/29/13.</p> <p>Physician orders for Resident #J, for the month of December, 2013 and signed by RN #1 on 11/26/13 did not include an order for Lamictal.</p> <p>The MAR for Resident #J, for the month of December, 2013, indicated the Lamictal was discontinued on</p>		<p>11/22/13, 11/23/13, 11/23/13, 11/25/13, 11/28/13, and 12/1/13 by the Licensed Nurse on 12/03/13. Resident #D was assessed by the Director of Clinical Services/Nurse Manager on 12/3/13 and resident did not experience any adverse effects. The Licensed Nurses assigned to Resident #D on 11/21/13, 11/22/13, 11/23/13, 11/25/13, 11/28/13, and 12/1/13 were re-educated by the RDCS/DCS/Nurse Manager by 12/15/13 to give medications as prescribed and document administration in the Medication Administration Record (MAR). Element #2 Residents' MAR and current Physician's Orders for December 2013 were reviewed by the Regional Director of Clinical Services (RDCS) on 12/6/13 thru 12/10/13 to identify discrepancies. The Physician and Responsible Party were notified by the DCS/Charge Nurse of any discrepancies that were identified and any new orders given to the nurse by the physician were implemented immediately. Element #3 The RDCS/DCS re-educated Licensed Nurses on the regulation F282, the Facility's Physician's Orders policy and to give medications as prescribed and document administration on the MAR. Element #4 The DCS/Nurse Manager will conduct Quality Improvement (QI) monitoring of residents'</p>				

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	<p>11/27/13.</p> <p>A current facility care plan for Resident #J, dated as initiated 7/5/11, indicated the problem area of life long history of depression. Approaches to the problem included, but were not limited to, evaluate effectiveness of psychopharmological intervention and observe for changes in mood status.</p> <p>The Regional Director of Clinical Services was interviewed on 12/2/13 at 2:30 p.m. During the interview she indicated the night shift nurse was assigned to review the physician orders for December, 2013, and did not transfer the new order for the Lamictal or recognize the error. She also indicated the missed medication would be treated as a medication error.</p> <p>2. Review of the clinical record for Resident #C on 12/2/13 at 1:00 p.m., indicated the following diagnoses included, but were not limited to: generalized and chronic pain, asymptomatic hypotension, nervous breakdown, MDD (Major Depression Disorder) with psychotic features, GERD (gastroesophageal reflux disease), encephalopathy, insomnia, pseudo dementia, anxiety.</p>		<p>Physician's Orders and residents' MAR for accuracy. The DCS/Nurse Manager will conduct QI monitoring 4 times a week for 8 weeks, then 2 times a week for eight weeks, then 1 time monthly for eight months using a sample size of 10 random residents. Areas of concern will be addressed immediately. The DCS/Nurse Manager will report results to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 12 months and/or the QAPI committee determines further actions are indicated.</p>		

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	<p>A Physician's Order received on 10/31/13 indicated Hydrocodone-APAP (Norco) 5/325 mg (milligrams) give 2 tablets PO (orally) every 8 hours PRN (as needed) for pain. The order on the MARS (Medication Administration Record Sheet) was originally dated on 10/31/13.</p> <p>Review of the MARS for Resident #C, for the dates of 11/20/13 through 12/2/13 indicated the following discrepancies:</p> <p>-On 11/23/13 the MARS indicated the medication was administered at 7:30 a.m. and 3:00 p.m. which indicated the Hydrocodone-APAP-325 mg was given 7 and 1/2 hours apart.</p> <p>-On 11/25/13 the MARS indicated the Hydrocodone-APAP-325 mg was given 7 hours and 15 minutes apart.</p> <p>3. The record review for Resident #D began on 12-2-2013 at 1:13 p.m. Diagnoses included but were not limited to: muscle spasms, degenerative joint disease, chronic pain, nerve pain, myofacial pain, chronic low back pain, depression, lumbago, sacroilitis, myalgia and myositis, neuropathic pain, lupus erythematosus, idiopathic peripheral</p>			

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	<p>neuropathy, anxiety, restless leg syndrome, and diabetes.</p> <p>The Physician recapitulation for December 2013 was reviewed by the RN on 11/26/2013. The November 2013 recapitulation was signed by the physician on 11-21-2013.</p> <p>A review of the physician's recapitulation for December 2013 indicated Resident #D had PRN (as needed) narcotic pain medication ordered as followed: "oxycodone - APAP 10-325 mg (milligrams) (Percocet) give 1 tablet orally every 6 hours as needed for pain (maximum 3/day)". The resident also had an order for "Opana ER 10 mg give 1 tab er [sic] 12H orally every 12 hours for chronic pain (max 2/day) (3 AM and 3 PM)." An order dated 9-20-2012 indicated "percocet and Opana ER are to be take at least 2 hours apart - monitor for sedation."</p> <p>A review of the MAR (Medication Administration Record) from 11-20-2013 through the second shift on 12-2-2013 indicated the following dates and times the oxycodone and Opana ER were administered less than two hours apart:</p> <p>On 11-21-2013, according to the</p>			

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	<p>MAR, the oxycodone was administered at 1:30 p.m. and the Opana ER was administered at 3:00 p.m.</p> <p>On 11-22-2013, according to the MAR, the oxycodone was administered at 2:00 p.m. and the Opana ER was administered at 3:00 p.m.</p> <p>On 11-23-2013, according to the MAR, the oxycodone was administered at 1:15 p.m. and the Opana ER was administered at 3:00 p.m.</p> <p>On 11-25-2013, according to the MAR, the oxycodone was administered at 2:00 p.m. and the Opana ER was administered at 3:00 p.m.</p> <p>On 11-28-2013, according to the MAR, the oxycodone was administered at 2:00 p.m. and the Opana ER was administered at 3:00 p.m.</p> <p>On 12-1-2013, according to the MAR, the oxycodone was administered at 1:30 p.m. and the Opana ER was administered at 3:00 p.m.</p> <p>During an interview with LPN #3 on</p>			

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	<p>12-3-2013 at 11:10 a.m., the LPN indicated for Resident #D, the Opana ER and the oxycodone was ordered to be given at least 2 hours apart. A review with LPN #3, of the MAR for the oxycodone for 12-1-2013 indicated the oxycodone was given at 1:30 p.m. and the MAR and the Controlled Substance Record indicated the Opana ER was administered at 3 p.m. The LPN indicated the oxycodone and Opana were given too close together at 1 and 1/2 hours instead of the 2 hours apart as ordered by the physician.</p> <p>A policy "Physician Orders" dated 1-4-2013 and provided by the Interim DON (Director of Nursing) on 12-3-2013 at 1:00 p.m., indicated "...a clinical nurse shall transcribe and review all physician orders in order to effect their implementation...the clinical nurse may accept a telephone order...shall be recorded exactly as the physician dictates it on a telephone order form...the order must then be transcribed to all appropriate areas (MAR, TAR, ect)...."</p> <p>This deficiency was cited on 10-29-2013 and the facility failed to implement their plan to correct the deficiency.</p>			

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	3.1-35(g)(2)				

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F000514 SS=E	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review the facility failed to maintain complete documentation of pain medications for 3 residents (Resident #J, Resident #C, and Resident #D) who were reviewed for pain medications. The facility further failed to ensure recognizable photographs of 3 residents, photographs of 10 residents, and names of 4 residents of 43 residents were placed under the divider tab for their correct room in the Medication Administration Record and the Treatment Administration Record.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #J began on 12/2/13 at 1:14</p>	F000514	F514Element #1Resident #J, Resident #C, and Resident #D showed no apparent adverse effect when reviewed by the DCS on 12/3/13. The 3 residents with photographs dark in color on the Treatment Administration Record (TAR) for East and West halls had their photographs replaced on 12/3/13 by the Social Services Director (SSD). The 2 residents lacking photographs on the MAR for West hall had photographs placed on the MAR on 12/3/13 by the SSD. The 3 residents lacking names on their photographs on the MAR for West hall had names placed on their pictures on the MAR on 12/3/13 by the SSD. The 7 residents lacking photographs on the MAR for East hall had photographs placed on the MAR on 12/3/13 by the SSD. The 2 residents lacking names on their photographs on the MAR for East	12/17/2013	

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	<p>p.m.</p> <p>A physician's order for Resident #J, dated 10/30/13, indicated Norco (narcotic pain medication) 5/325 mg (milligrams) q (every) 4 hours for pain PRN (as needed).</p> <p>Review of the Medication Record, the Controlled Substances Record, and the Pain Flow Sheet for Resident #J, for the month of November, 2013, indicated the following discrepancies:</p> <ul style="list-style-type: none"> <li>- On 11/20/13 the Medication Record lacked documentation to indicate Norco 5/325 mg was given at 4:15 p.m. and 8:30 p.m. The Controlled Substances Record for the same date indicated Norco 5/325 mg was signed out by staff at 4:15 p.m. and 8:30 p.m. The Pain Flow Sheet did not indicate her pain was assessed at 4:15 p.m. or at 8:30 p.m.</li> <li>- On 11/22/13 the Medication Record lacked documentation to indicate Norco 5/325 mg was given at 5:00 p.m. The Controlled Substances Record for the same date indicated Norco 5/325 mg was signed out by staff at 8:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.</li> <li>- On 11/23/13 the Medication Record</li> </ul>		<p>hall had names placed on their pictures on the MAR on 12/3/13 by the SSD. LPN #2 was re-educated by the RDCS by 12/15/13 to ensure residents' photographs are present on the Medication Administration Record and the Treatment Administration Record (MAR/TAR), that the pictures are recognizable and that they have the residents' name clearly identified on the photograph and to notify the DCS/Executive Director of any discrepancies. Element #2Current Residents, who receive Pro Re Nata (PRN/As Needed) Narcotic Pain Medication, had their MAR and Physician's Orders for December 2013 reviewed by the Regional Director of Clinical Services (RDCS) on 12/6/13 thru 12/10/13 to identify discrepancies. The Physician and Responsible Party were notified by the DCS/Charge Nurse of any discrepancies that were identified and any new orders given to the nurse by the physician were implemented immediately. Residents' MAR/TAR were reviewed by the Social Services Director (SSD) on 12/5/13 and 12/6/13 to ensure each resident had a photograph that was present and recognizable with the resident's name clearly identified on the photograph. Any discrepancies were immediately corrected by the SSD, at that time. ELEMENT #3The RDCS/DCS re-educated</p>				

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	<p>lacked documentation to indicate Norco 5/325 mg was given at 3:00 a.m., 4:00 p.m., and 8:00 p.m. The Controlled Substances Record for the same date indicated Norco 5/325 mg was signed out by staff at 3:00 a.m., 9:00 a.m., 4:00 p.m., and 8:00 p.m. The Pain Flow Sheet did not indicate her pain was assessed at 4:00 p.m. or 8:00 p.m.</p> <p>- On 11/24/13 the Medication Record lacked documentation to indicate Norco 5/325 mg was given at 8:30 p.m. The Controlled Substances Record for the same date indicated Norco 5/235 mg was signed out by staff at 9:00 a.m., 3:30 p.m., and 8:30 p.m.</p> <p>- On 11/27/13 the Medication Record lacked documentation to indicate Norco 5/325 mg was given at 3:15 a.m. The Controlled Substances Record for the same date indicated Norco 5/325 mg was signed out by staff at 3:15 a.m., 8:00 a.m., 1:00 p.m., and 7:45 p.m.</p> <p>Review of the Medication Record, the Controlled Substances Record, and the Pain Flow Sheet for Resident #J, for the month of December, 2013, indicated the following discrepancies:</p>		<p>Licensed Nurses to ensure each resident has a photograph that is present on the MAR/TAR, and are recognizable with the resident's name clearly identified on the photographs. Also, Licensed Nurses were re-educated that they are to notify the ED/DCS immediately when a photograph is either not in the MAR/TAR, recognizable, or does not have the residents' name clearly identified on the photograph. The RD/DCS re-educated Licensed Nurses on documentation for PRN Narcotic Pain Medication Administration. Licensed Nurses are to complete the Pain Assessment Flow Sheet, the Controlled Substances Record, and they are to document on the front of the MAR for PRN Narcotic Pain Medication given. Licensed Nurses are to follow the prescribed time for administration per the physician's order. Element #4 The DCS/Nurse Manager will conduct Quality Improvement monitoring of Residents' records to ensure that PRN Narcotic Pain Medications administered are documented on the Pain Assessment Flow Sheet, the Controlled Substances Record and the front of the MAR. DCS/ Nurse Manager will conduct Quality Improvement (QI) monitoring 4 times weekly for eight weeks, then 2 times weekly for eight weeks, then 1 time monthly for eight months using a sample size of 10 random</p>	

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	<p>- On 12/1/13 the Medication Record lacked documentation to indicate Norco 5/325 mg was given at 1:15 p.m. The Controlled Substances Record for the same date indicated Norco 5/325 mg was signed out by staff at 9:15 a.m., 1:15 p.m., and 7:30 p.m.</p> <p>2. Review of the clinical record for Resident #C began on 12/2/13 at 1:00 p.m.</p> <p>A Physician's Orders received on 10/31/13 indicated Hydrocodone-APAP (Norco) 5/325 mg (milligrams) give 2 tablets PO (orally) every 8 hours PRN (as needed) for pain. The order on the MARS (Medication Administration Record Sheet) was originally dated on 10/31/13.</p> <p>Review of the MARS, the Pain Flow Sheet, and the Controlled Substances Record for Resident #C, for the dates of 11/20/13 through 12/2/13 indicated the following discrepancies:</p> <p>- On 11/20/13 the MARS did not indicate Hydrocodone-APAP 5-325 mg was given during the 24 hour period. The Controlled Substances Record for the same date indicated</p>		<p>residents. Areas of concern will be addressed immediately. The DCS/Nurse Manager will report the findings to the QAPI Committee monthly for 12 months and/or until substantial compliance. Additionally, the ED/Social Services Director (SSD) will review residents' MAR/TAR to ensure that residents have photographs present which are recognizable and clearly identifiable with the resident's name. The ED/SSD will conduct Quality Improvement (QI) monitoring 4 times weekly for eight weeks, then 2 times weekly for eight weeks, then 1 time monthly for eight months using a sample size of 10 random residents. Areas of concern will be addressed immediately. The ED/SSD will report results to the QAPI Committee monthly for 12 months and/or the QAPI committee determines further actions are indicated.</p>		

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	<p>Hydrocodone-APAP 5-325 mg, 2 tablets were signed out by staff at 7:15 a.m. and 3:30 p.m.</p> <p>- On 11/21/13 the MARS indicated Hydrocodone-APAP 5-325 mg was given at 5:00 p.m.. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 2 tablets were signed out by the staff at 4:30 p.m.. There was no documentation on the Pain Flow Sheet on 11/21/13.</p> <p>-On 11/23/13 the MARS lacked documentation to indicate Hydrocodone-APAP 5-325 mg was given at 3:00 p.m. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 2 tablets were signed out at 7:30 a.m. and 3:00 p.m..</p> <p>-On 11/24/13 the MARS lacked documentation to indicate Hydrocodone-APAP 5-325 mg was given at 3:15 p.m. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 2 tablets were signed out at 7:15 a.m. and 3:15 p.m.</p> <p>3. During a clinical record review for photographs of all Residents on the TARS (Treatment Administration</p>			

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	<p>Record Sheet) for the East and West Halls on 12/3/13 at 9:45 a.m. these discrepancies were found:</p> <ul style="list-style-type: none"> <li>- Three residents' photographs were dark in color and the resident 's faces were unidentifiable.</li> </ul> <p>An interview with the Regional Director of Clinical Services (RDCS) on 12/3/13 at 2:20 p.m., indicated there were 3 residents pictures that were too dark in color and were unidentifiable.</p> <ul style="list-style-type: none"> <li>- During a clinical record review for Resident 's photographs on the MARS (Medication Administration Record Sheet) for the West Hall on 12/3/13 at 10:15 a.m., indicated there were no photographs in the MARS for 2 residents. There were no names on 3 photographs of residents.</li> </ul> <p>During an interview with LPN #3 on 12/3/13 at 11:45 a.m., she indicated there should be a photograph with the Resident 's name on their picture in the MARS and the picture of the resident was to be placed in the divider tab for their room number. She indicated there was not a photograph for the 2 residents identified in the MARS and the name of the resident was not on the front of</p>			

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	<p>the pictures for 3 residents.</p> <p>- During a clinical record review for Resident ' s photographs on the MARS for the East Hall on 12/3/13 at 10:50 a.m., indicated there were no photographs in the MARS for 7 residents and there were no names on 2 photographs of residents.</p> <p>During an interview with LPN #2 on 12/3/13 at 11:35 a.m., she indicated the Residents were identified during medication administration by their photographs in the MARS and TARS. She also indicated photographs should have their name on their pictures. She indicated the photographs are located in the divider tabs with their room number written on the tab. She indicated several of the resident ' s photographs were not on the MARS. She indicated she was not sure who was responsible to make sure the photographs were placed in the MARS.</p> <p>During an interview with the RDCS on 12/3/13 at 12:00 p.m., she indicated there should be photographs of all of the Residents in the MARS and TARS for the staff to identify the residents receiving medications and treatments.</p>			

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	<p>4. The record review for Resident #D began on 12-2-2013 at 1:13 p.m.</p> <p>The Physician recapitulation for December 2013 was reviewed by the RN on 11/26/2013. The November 2013 recapitulation was signed by the physician on 11-21-2013.</p> <p>A review of the physician's recapitulation for December 2013 indicated Resident #D had PRN (as needed) narcotic pain medication ordered as followed: "oxycodone - APAP 10-325 mg (Percocet) give 1 tablet orally every 6 hours as needed for pain (maximum 3/day)".</p> <p>A review of the Medication Administration Record (MAR), the Pain Flow Sheet and the Controlled Substances Record for Resident #D, from November 20, 2013 and through the second shift on December 2, 2013 indicated the following discrepancies for Resident #D's oxycodone:</p> <p>On 11-22-2013, the MAR lacked documentation to indicate oxycodone was administered at 5:45 a.m. and 2:00 p.m. and the Pain Flow Sheet lacked the pain assessment for the</p>			

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	<p>5:45 a.m. dose. The Controlled Substances Record indicated the oxycodone was signed out at 5:45 a.m. and 2:00 p.m.</p> <p>On 11-23-2013, the MAR and the Pain Flow Sheet lacked documentation to indicate oxycodone was administered at 9:45 p.m. The Controlled Substances Record indicated the oxycodone was signed out at 9:45 p.m.</p> <p>On 11-30-2013, the MAR lacked documentation to indicate oxycodone was administered at 2:00 p.m. The Controlled Substances Record indicated the oxycodone was signed out at 2:00 p.m.</p> <p>During an interview with the Interim DON (Director of Nursing) on 12-2-2013 at 3:20 p.m., the DON indicated for residents who received PRN (as needed) narcotic pain medication, their records were audited to verify the following: the order on the MAR matched exactly as the physician's order was written, the MAR was signed/initialed by the nurse to indicate the narcotic was given as ordered by the physician, the Pain Flow Sheet documentation dates and times matched the MAR and the Resident's Controlled Substance</p>			

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	<p>Record matched the MAR and the Pain Flow Sheet. The Interim DON indicated documentation was not required on the Nurse's Medication Notes (on the back side of the MAR) for the narcotic pain medication as it would just be a duplicate of the Pain Flow Sheet documentation.</p> <p>During an interview with the Regional Director of Clinical Services (RDCS) on 12-3-2013 at 9:30 a.m., the RDCS indicated there was not a policy for PRN narcotic pain medication administration that directed the nurse to document on the Controlled Substance Record, the MAR and the Pain Flow Sheet in one place. The RDCS indicated there was not a policy that directed the nurse to document PRN narcotic pain medication administration on the back of the MAR on the Nurse's Medication Notes.</p> <p>During an interview with LPN #2 on 12-3-2013 at 11:05 a.m., the LPN indicated documentation for PRN narcotic pain medication included the pain assessment (Pain Flow Sheet), the MAR, Back of the MAR (Nurses Medication Notes) and on the Controlled Substance Record.</p> <p>During an interview with LPN #3 on</p>			

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	<p>12-3-2013 at 11:10 a.m., the LPN indicated documentation for a PRN narcotic pain medication included the pain assessment (Pain Flow Sheet), the MAR, and the Narcotic Count Sheet (Controlled Substance Record).</p> <p>A policy "Oral Administration of Medications" dated 9-1-2011 and provided by the Regional Director of Clinical Services on 12-3-2013 at 12:00 p.m., indicated "...verify physician's order...check resident's picture/ID...administer oral drug...chart on MAR...."</p> <p>A current policy "Pain Assessment" dated 9-1-2011 and provided by the Regional Director of Clinical Services on 12-3-2013 at 12:00 p.m., indicated "...a Pain Flow Record will be maintained with the resident's Medication Administration Record...this is to be completed when the resident has identified they have pain...record the following: date and time, site/location, type of pain, intensity, precipitating/aggravating, interventions - non-med/medication, intensity of pain after intervention, side effects, initials...."</p> <p>This deficiency was cited on 10-29-2013 and the facility failed to</p>			

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	implement their plan to correct the deficiency.  3.1-50(a)(1)				