

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/30/2013
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NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
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F000000	<p>This visit was for the Investigation of Complaint IN00121579 and Complaint IN00121604.</p> <p>Complaint IN00121579 Substantiated, federal/state deficiencies related to the allegations are cited at F224, F226, F282, F309, and F425.</p> <p>Complaint IN00121604 Substantiated, federal/state deficiencies related to the allegations are cited at F224, F226, F282, F309, and F425.</p> <p>Survey dates: January 25, 28, and 30, 2013</p> <p>Facility number: 000109 Provider number: 155202 AIM number: 100266290</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF/NF: 77 Total: 77</p> <p>Census payor type: Medicare: 10 Medicaid: 50 Other: 17</p>	F000000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 28, 2013.	

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>Total: 77</p> <p>Sample: 3 Expanded sample: 3</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 02/06/2013 by Brenda Nunan, RN.</p>			

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F000224 SS=E	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure residents were free of misappropriation of property for 1 of 3 sampled residents and 3 of 3 residents in an expanded sample reviewed for misappropriation of residents' medications [Resident C, D, E, and F].</p> <p>Findings include:</p> <p>During an interview on 01/28/13 at 9:50 a.m., the Assistant Director of Nursing [ADON] indicated a large volume of Hydrocodone-Oxycodone (narcotic pain medication) tablets were discovered missing from residents' medication supplies during November 2012.</p> <p>During an interview on 01/28/13 at 10:00 a.m., the Director of Nursing [DON] indicated 11, 549 doses of narcotics prescribed for resident's C, D, E, F and other residents residing on Misty Lane West, were missing</p>	F000224	<p>It is the intent of this facility to ensure residents are free of misappropriation of property and that written policies and procedures are implemented to prohibit mistreatment, neglect, and abuse of residents. 1. Action Taken a. Staff in-serviced on policy and procedures of abuse prohibition and misappropriation of property. b. Nurses in-serviced on Narcotic Policy and Procedures. c. DON\designee will audit narcotic binder\drawer for accuracy, randomly observe at least 5 narcotic counts per week for 4 weeks, and then observe 3 narcotic counts for 4 weeks and then ongoing randomly observe 1 narcotic count per week. All observations will be reviewed at CQI meeting. d. DON\designee to compared packing slips against narcotic medications with initiation of new policy. e. Narcotic report received from pharmacy weekly by DON\designee compared to packing slips with initiation of new policy. 2. Others Identified a. 100% audit of all narcotics have been completed. b. All missing</p>	02/28/2013			

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	<p>from the medication cart between August and November 2012.</p> <p>A facility "Incident Report", dated 11/17/12 indicated Oxycodone was missing from residents' medication supplies.</p> <p>1. Review of Resident C's closed clinical record, on 01/25/13 at 12:40 p.m., indicated Resident C resided on Misty Lane West and had diagnoses which included, but were not limited to, pneumonia, chronic kidney disease, coronary artery disease, dysphagia, hypertension, multiple myeloma, peripheral neuropathy, anemia secondary to gastro-intestinal bleed, colitis, and history of congestive heart failure.</p> <p>Resident C's August 2012 medication records indicated medications included, but were not limited to, Hydrocodone/APAP 5/325 mg. (milligrams) 1-2 tablets every 4-6 hours as needed for pain, not to exceed 3 gm (grams) in 24 hours.</p> <p>The facility investigation provided by the DON on 01/28/13 at 9:00 a.m., and identified as ongoing, indicated the "Controlled Drug Receipt Record/Disposition Forms" were compared with the pharmacy</p>		<p>narcotics identified were replaced by facility. 3. Systems in Place a. Nurses and QMA's in-serviced on Narcotic Policy. 4. Monitoring a. DON\designee will audit narcotic binder\drawer for accuracy, randomly observe at least 5 narcotic counts per week for 4 weeks, and then observe 3 narcotic counts for 4 weeks and then ongoing randomly observe 1 narcotic count per week. All observations will be reviewed at the CQI meeting. b. DON\designee available 24\7 to answer questions, and/or provide additional education on new policy. c. Narcotic report, which is received from pharmacy weekly by DON\designee will be compared to packing slips on an ongoing basis to ensure accuracy of medications delivered. d. Any issues\findings identified will be immediately addressed. Any issues identified will be discussed at the CQI meeting. Any findings will be discussed with Medical Director at Quarterly QA meetings and/or as needed. 5. Date of Compliance: 2\28\2013</p>		

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	<p>"Monthly Controlled Drug Reports" and "Shift to Shift (narcotic) Count" and the "Narcotic and Controlled Drug Reports" for August 2012. The comparisons indicated the pharmacy dispensed 3 medication cards, with a total of 90 tablets of Hydrocodone/APAP 5/325 mg, on 08/07/12. The facility investigation indicated 1 medication card (30 pills) was unaccounted for during the reconciliation process. The investigation report indicated 30 Hydrocodone/APAP tablets prescribed for Resident C were delivered to facility on 08/18/12. The report indicated the medications were missing from the resident's supply of medication. The report indicated a physician order, dated 09/04/12, for Hydrocodone/APAP 5/325 mg every 4 hours, 180 tablets, with 5 refills. The report indicated 180 tablets were delivered to Resident C's medication supply on 09/04/12 and 120 tablets were delivered to Resident C's medication supply on 09/17/12. The investigation report indicated 90 tablets were missing from the resident's supply.</p> <p>2. Resident D's clinical record was reviewed on 01/28/13 at 3 p.m. and indicated Resident D had diagnoses which included, but were not limited</p>				

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	<p>to, dementia, anemia, hypertension, hyperlipidemia, diabetes, urinary tract infection, and hypothyroidism.</p> <p>Resident D's Physician's orders for August, September, October, and November, 2012 indicated medications which included, but were not limited to, Oxycodone/APAP 5/325 mg, take 1-2 tablets by mouth every 4-6 hours as needed.</p> <p>The facility investigation provided by the DON on 01/28/13 at 9:00 a.m., and identified as ongoing, indicated 60 tablets of Oxycodone/APAP 5/325 mg were missing from Resident D's medication supply after a pharmacy delivery on 07/23/12. The investigation report indicated 60 tablets were missing from Resident D's medication supply on 08/15/12, 90 tablets were missing from the resident's supply following a pharmacy delivery on 08/24/12. The investigation summary indicated additional medications missing from Resident D's medication supply following pharmacy deliveries included: 60 tablets on 09/03/12, 90 tablets on 09/17/12, 90 tablets on 09/26/12, 60 tablets on 10/05/12, 60 tablets on 10/27/12, 90 tablets on 11/06/12, and 60 tablets on 11/16/12.</p>			

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	<p>3. Resident E's clinical record was reviewed on 01/28/13 at 3:30 p.m. and indicated Resident E had diagnoses which included, but were not limited to, anemia, dementia, hypertension, hip fracture, aphasia, osteoporosis, difficulty walking, malaise, and fatigue.</p> <p>Physician's orders dated August 2012, indicated, "...Hydrocodone/APAP 5/325 mg take 1 tablet by mouth every 4 hours...Hydrocodone/APAP 5/325 mg take 1 tablet by mouth every 4 hours as needed."</p> <p>The facility investigation provided by the DON on 01/28/13 at 9:00 a.m., and identified as ongoing, indicated 120 tablets of Hydrocodone/APAP 5/325 mg were missing from Resident E's medication supply on 07/12/12, 90 tablets were missing on 08/07/12, 120 tablets were unaccounted for on 08/28/12, and 90 tablets were missing from Resident E's medication supply on 09/01/12.</p> <p>Physician's orders, dated 09/11/12, indicated Hydrocodone/APAP was changed from 5/325 mg every 4 hours as needed to Hydrocodone 10/325 mg 1 three times daily and 1 tablet every 4 hours as needed for</p>						

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	<p>pain.</p> <p>The facility investigation provided by the DON on 01/28/13 at 9:00 a.m., and identified as ongoing, indicated 90 tablets of Hydrocodone/APAP 10/325 mg were missing from Resident E's medication supply on 09/11/12. The report indicated 90 tablets were missing on 09/29/12, 120 tablets were missing from the medication supply on 10/22/12, and 120 tablets were missing from Resident E's medication supply on 11/09/12.</p> <p>4. Resident F's clinical record was reviewed on 01/28/13 at 4 p.m., and indicated Resident F had diagnoses which included, but were not limited to, pneumonia, hypertension, aphasia, cerebrovascular accident, depression, dysphagia, neuritis, muscle spasm, and chronic obstructive pulmonary disease.</p> <p>Resident F's medications included, but were not limited to, Hydrocodone/APAP 5/500 mg every 4 hours as needed, Hydrocodone/APAP 5/325 mg every 4 hours as needed, and Hydrocodone/APAP 10/325 mg three times a day (scheduled) and every 4 hours as needed.</p>						

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	<p>The facility investigation provided by the DON on 01/28/13 at 9:00 a.m., and identified as ongoing, indicated 30 tablets of Hydrocodone/APAP 5/325 mg were missing from Resident F's medication supply on 10/11/12 and 30 tablets of Hydrocodone 5/325 mg were unaccounted for on 11/21/12. The investigation indicated 60 tablets of Hydrocodone/APAP 10/325 mg were missing from the resident's medication supply on 07/29/12, 90 tablets were unaccounted for on 08/31/12, and 60 tablets were missing from Resident F's medication supply on each of the following dates: 08/25/12, 09/06/12, 09/18/12, and 10/09/12.</p> <p>The facility's "Abuse-Misappropriation of Funds/Property" policy, dated 07/01/2011, and identified by the DON as current, indicated, "It is the intent of the facility to safeguard resident property (to the extent possible) to assure that there is no exploitation of residents through misappropriation of their property...If the investigation/search reveals suspect misappropriation of resident's property refer to the abuse prohibition protocol."</p> <p>The facility's policy for "Abuse</p>						

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	<p>Prohibition." dated 07/01/2011, identified by the DON as current, indicated, "It is the intent of this facility to maintain an environment free of abuse and neglect. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of their property (collectively, sometimes referred to as "events"). Residents will not be subject to such events by anyone including, but not limited to, facility staff, other residents, consultants, or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. This facility shall comply with all federal and state requirements to screen, train, prevent, identify, investigate, protect and report, if applicable, any event that is not consistent with the usual operation of nursing facility or the standard care for certain residents. The facility will not condone abuse of any type by anyone including staff members, other residents, volunteers, family, legal guardian, friends, visitors or other individuals."</p> <p>This federal finding relates to Complaint IN00121579 and Complaint IN00121604.</p>			

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F000226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement written policies and procedures that prohibit misappropriation of resident's properties for 1 of 3 sampled residents and 3 of 3 in an expanded sample reviewed for misappropriation of residents' medications [Residents C, D, E, and F].</p> <p>Findings include:</p> <p>During an interview on 01/28/13 at 9:50 a.m., the Assistant Director of Nursing [ADON] indicated a large volume of Hydrocodone-Oxycodone (narcotic pain medication) tablets were discovered missing from residents' medication supplies during November 2012.</p> <p>During an interview on 01/28/13 at 10:00 a.m., the Director of Nursing [DON] indicated 11, 549 doses of narcotics prescribed for resident's C, D, E, F and other residents residing on Misty Lane West, were missing from the medication cart between</p>	F000226	<p>It is the intent of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1. Action Taken a. Staff in-serviced on policy and procedures of abuse prohibition and misappropriation of property. b. Nurses in-serviced on Narcotic Policy and Procedures. c. DON\designee will audit narcotic binder\drawer for accuracy, randomly observe at least 5 narcotic counts per week for 4 weeks, and then observe 3 narcotic counts for 4 weeks and then ongoing randomly observe 1 narcotic count per week. All observations will be reviewed at CQI meeting. d. DON\designee to compare packing slips against narcotic medications with initiation of new policy. e. Narcotic report received from pharmacy weekly by DON or designee compared to packing slips with initiation of new policy. 2. Others Identified a. 100% audit of all narcotics has been completed. b. All missing narcotics identified were replaced by facility. 3. Systems in Place a. Nurses and QMA's in-serviced</p>	02/28/2013

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	<p>August and November 2012.</p> <p>A facility "Incident Report", dated 11/17/12 indicated Oxycodone was missing from residents' medication supplies.</p> <p>1. Review of Resident C's closed clinical record, on 01/25/13 at 12:40 p.m., indicated Resident C resided on Misty Lane West and had diagnoses which included, but were not limited to, pneumonia, chronic kidney disease, coronary artery disease, dysphagia, hypertension, multiple myeloma, peripheral neuropathy, anemia secondary to gastro-intestinal bleed, colitis, and history of congestive heart failure.</p> <p>Resident C's August 2012 medication records indicated medications included, but were not limited to, Hydrocodone/APAP 5/325 mg. (milligrams) 1-2 tablets every 4-6 hours as needed for pain, not to exceed 3 gm (grams) in 24 hours.</p> <p>The facility investigation provided by the DON on 01/28/13 at 9:00 a.m., and identified as ongoing, indicated the "Controlled Drug Receipt Record/Disposition Forms" were compared with the pharmacy "Monthly Controlled Drug Reports"</p>		<p>on Narcotic Policy. 4. Monitoring a. DON\designee will audit narcotic binder\drawer for accuracy, randomly observe at least 5 narcotic counts per week for 4 weeks, and then observe 3 narcotic counts for 4 weeks and then ongoing randomly observe 1 narcotic count per week. All observations will be reviewed at the CQI meeting. b. DON\designee available 24\7 to answer questions, and\or provide additional education on new policy. c. Narcotic report, which is received from pharmacy weekly by DON\designee will be compared to packing slips on an ongoing basis to ensure accuracy of medications delivered. d. Any issues\findings identified will be immediately addressed. Any issues identified will be discussed in CQI meeting. Any findings will be discussed with Medical Director at Quarterly QA meetings and\or as needed. 5. Date of Compliance: 2\28\2013</p>				

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	<p>and "Shift to Shift (narcotic) Count" and the "Narcotic and Controlled Drug Reports" for August 2012. The comparisons indicated the pharmacy dispensed 3 medication cards, with a total of 90 tablets of Hydrocodone/APAP 5/325 mg, on 08/07/12. The facility investigation indicated 1 medication card (30 pills) was unaccounted for during the reconciliation process. The investigation report indicated 30 Hydrocodone/APAP tablets prescribed for Resident C were delivered to facility on 08/18/12. The report indicated the medications were missing from the resident's supply of medication. The report indicated a physician order, dated 09/04/12, for Hydrocodone/APAP 5/325 mg every 4 hours, 180 tablets, with 5 refills. The report indicated 180 tablets were delivered to Resident C's medication supply on 09/04/12 and 120 tablets were delivered to Resident C's medication supply on 09/17/12. The investigation report indicated 90 tablets were missing from the resident's supply.</p> <p>2. Resident D's clinical record was reviewed on 01/28/13 at 3 p.m. and indicated Resident D had diagnoses which included, but were not limited to, dementia, anemia, hypertension,</p>			

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	<p>hyperlipidemia, diabetes, urinary tract infection, and hypothyroidism.</p> <p>Resident D's Physician's orders for August, September, October, and November, 2012 indicated medications which included, but were not limited to, Oxycodone/APAP 5/325 mg, take 1-2 tablets by mouth every 4-6 hours as needed.</p> <p>The facility investigation provided by the DON on 01/28/13 at 9:00 a.m., and identified as ongoing, indicated 60 tablets of Oxycodone/APAP 5/325 mg were missing from Resident D's medication supply after a pharmacy delivery on 07/23/12. The investigation report indicated 60 tablets were missing from Resident D's medication supply on 08/15/12, 90 tablets were missing from the resident's supply following a pharmacy delivery on 08/24/12. The investigation summary indicated additional medications missing from Resident D's medication supply following pharmacy deliveries included: 60 tablets on 09/03/12, 90 tablets on 09/17/12, 90 tablets on 09/26/12, 60 tablets on 10/05/12, 60 tablets on 10/27/12, 90 tablets on 11/06/12, and 60 tablets on 11/16/12.</p> <p>3. Resident E's clinical record was</p>						

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	<p>reviewed on 01/28/13 at 3:30 p.m. and indicated Resident E had diagnoses which included, but were not limited to, anemia, dementia, hypertension, hip fracture, aphasia, osteoporosis, difficulty walking, malaise, and fatigue.</p> <p>Physician's orders dated August 2012, indicated, "...Hydrocodone/APAP 5/325 mg take 1 tablet by mouth every 4 hours...Hydrocodone/APAP 5/325 mg take 1 tablet by mouth every 4 hours as needed."</p> <p>The facility investigation provided by the DON on 01/28/13 at 9:00 a.m., and identified as ongoing, indicated 120 tablets of Hydrocodone/APAP 5/325 mg were missing from Resident E's medication supply on 07/12/12, 90 tablets were missing on 08/07/12, 120 tablets were unaccounted for on 08/28/12, and 90 tablets were missing from Resident E's medication supply on 09/01/12.</p> <p>Physician's orders, dated 09/11/12, indicated Hydrocodone/APAP was changed from 5/325 mg every 4 hours as needed to Hydrocodone 10/325 mg 1 three times daily and 1 tablet every 4 hours as needed for pain.</p>			

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	<p>The facility investigation provided by the DON on 01/28/13 at 9:00 a.m., and identified as ongoing, indicated 90 tablets of Hydrocodone/APAP 10/325 mg were missing from Resident E's medication supply on 09/11/12. The report indicated 90 tablets were missing on 09/29/12, 120 tablets were missing from the medication supply on 10/22/12, and 120 tablets were missing from Resident E's medication supply on 11/09/12.</p> <p>4. Resident F's clinical record was reviewed on 01/28/13 at 4 p.m., and indicated Resident F had diagnoses which included, but were not limited to, pneumonia, hypertension, aphasia, cerebrovascular accident, depression, dysphagia, neuritis, muscle spasm, and chronic obstructive pulmonary disease.</p> <p>Resident F's medications included, but were not limited to, Hydrocodone/APAP 5/500 mg every 4 hours as needed, Hydrocodone/APAP 5/325 mg every 4 hours as needed, and Hydrocodone/APAP 10/325 mg three times a day (scheduled) and every 4 hours as needed.</p>			

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	<p>The facility investigation provided by the DON on 01/28/13 at 9:00 a.m., and identified as ongoing, indicated 30 tablets of Hydrocodone/APAP 5/325 mg were missing from Resident F's medication supply on 10/11/12 and 30 tablets of Hydrocodone 5/325 mg were unaccounted for on 11/21/12. The investigation indicated 60 tablets of Hydrocodone/APAP 10/325 mg were missing from the resident's medication supply on 07/29/12, 90 tablets were unaccounted for on 08/31/12, and 60 tablets were missing from Resident F's medication supply on each of the following dates: 08/25/12, 09/06/12, 09/18/12, and 10/09/12.</p> <p>The facility's "Abuse-Misappropriation of Funds/Property" policy, dated 07/01/2011, and identified by the DON as current, indicated, "It is the intent of the facility to safeguard resident property (to the extent possible) to assure that there is no exploitation of residents through misappropriation of their property...If the investigation/search reveals suspect misappropriation of resident's property refer to the abuse prohibition protocol."</p> <p>The facility's policy for "Abuse Prohibition." dated 07/01/2011,</p>				

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	<p>identified by the DON as current, indicated, "It is the intent of this facility to maintain an environment free of abuse and neglect. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of their property (collectively, sometimes referred to as "events"). Residents will not be subject to such events by anyone including, but not limited to, facility staff, other residents, consultants, or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. This facility shall comply with all federal and state requirements to screen, train, prevent, identify, investigate, protect and report, if applicable, any event that is not consistent with the usual operation of nursing facility or the standard care for certain residents. The facility will not condone abuse of any type by anyone including staff members, other residents, volunteers, family, legal guardian, friends, visitors or other individuals."</p> <p>This federal finding relates to Complaint IN00121579 and Complaint IN00121604.</p>			

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F000282 SS=E	<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 nursing staff were following physician's orders for 1 of 3 residents in a sample of 3 and for 3 of 3 residents in an expanded sample [Resident C, D, E, and F].</p> <p>Findings include:</p> <p>1. Review of Resident C's closed clinical record, on 01/25/13 at 12:40 p.m., indicated Resident C resided on Misty Lane West and had diagnoses which included, but were not limited to, pneumonia, chronic kidney disease, coronary artery disease, dysphagia, hypertension, multiple myeloma, peripheral neuropathy, anemia secondary to gastro-intestinal bleed, colitis, and history of congestive heart failure.</p> <p>Resident C's medications were reviewed for the month of August 2012. Resident C's medications included, but were not limited to, Hydrocodone/APAP 5/325 mg. Resident C was to take 1 - 2 tablets</p>	F000282	<p>It is the intent of this facility to ensure nursing staff follow physicians orders. 1. Action Taken a. Nurses and QMA's in-serviced on medication administration policy, and the PRN Controlled Drug Receipt/Record Disposition Form. 2. Others Identified a. Nurses and QMA's will be audited on medication administration competency. Competency's initiated and will be ongoing with all nurses\QMA's prior to initiation of shift. Results discussed in CQI meeting and any negative findings that were identified were corrected during in-service training. 3. Systems in Place a. DON\designee will review all new orders on at the CQI meeting. b. The PRN Controlled Drug Receipt\Record Disposition Form will be audited 5 times per week for four weeks, then audited 3 times per week, and then ongoing on a one time per week basis to ensure that medications are being administered per physician order. 4. Monitoring a. DON\designee will perform random nurse medication pass proficiency audit 3 times weekly for ninety days and then randomly weekly proficiencies will be on-going.</p>	02/28/2013			

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	<p>by mouth every 4-6 hours as needed for pain. Max does was 3 gm (grams)/24 hours.</p> <p>The Physician's Recapitulation, dated August 2012, indicated Resident C was prescribed Hydrocodone/APAP 5/325 mg 1-2 tablets by mouth every 4-6 hours as needed for pain. The Controlled Substance Record and Medication Administration Records [MAR], dated August 2012, indicated LPN #7 administered doses outside prescribed parameters on the following dates: -08/01/12 at 7 a.m., 10 a.m., 12 p.m., and 1 p.m. -08/02/12 at 6 a.m., 7 a.m., 10 a.m., 11 a.m., and 1 p.m. -08/06/12 at 6:30 a.m., and 9:30 a.m. -08/07/12 at 7 a.m., 10 a.m., and 1 p.m. -08/14/12 at 7 a.m., 10 a.m., and 12 p.m. -08/15/12 at 3 a.m., 6 a.m., 10 a.m., and 1:40 p.m. -08/17/12 at 3 a.m., 6 a.m., and 10 a.m. -08/30/12 at 7 and 11 a.m. and 2 p.m. -08/31/12 at 3 a.m. and 6 a.m. (double entries)</p> <p>Interview with the Director of Nursing (DON) on 01/28/13 at 10 a.m., indicated Resident C's record</p>		<p>Any findings will be immediately addressed with further in-servicing as needed or appropriate. Any issues/findings will be immediately addressed. Any issues identified will be discussed at the CQI meeting. Any findings will be discussed with Medical Director at quarterly QA meetings and/or as needed.</p> <p>5. Date of Compliance: 2\28\2013</p>				

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	<p>indicated pain medications were signed out for administration more frequently than ordered by the physician.</p> <p>2. Resident D's clinical record was reviewed on 01/28/13 at 3 p.m. and indicated Resident D had diagnoses which included, but were not limited to, dementia, anemia, hypertension, hyperlipidemia, diabetes, urinary tract infection, and hypothyroidism.</p> <p>The Physician's Recapitulation, dated August 2012, indicated Resident D was prescribed Hydrocodone 5/325 mg 1-2 tablets by mouth every 4-6 hours as needed for pain and in September, October, and November 2012, Oxycodone/APAP 5/325 mg 1-2 tablets by mouth every 4 hours as needed for pain. The Controlled Substance Record and MAR's, dated August 2012, indicated LPN #7 administered doses outside prescribed parameters on the following dates: -08/01/12 at 7 a.m., 10 a.m., and 1 p.m., -08/02/12 at 7 a.m., 10 a.m., and 1 p.m. -08/03/12 at 3 a.m., 6 a.m., 7 a.m., 10 a.m., and 1 p.m. -08/06/12 at 6:30 a.m., 9:30 a.m., 12 p.m. and 2:30 p.m.</p>			

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	-08/07/12 at 7 a.m., 10 a.m., and 1 p.m. -08/08/12 at 3 a.m., 6 a.m., 10 a.m., and 1 p.m. -08/09/12 at 3 a.m., 6 a.m., 10 a.m., and 1 p.m. -08/10/12 at 3 a.m., 6 a.m., 10 a.m., and 1 p.m. -08/11/12 at 7 a.m., 10 a.m., 1 p.m., and 4:30 p.m. -08/12/12 at 7 a.m., 10 a.m., 1 p.m., and 5 p.m. -08/13/12 at 7 a.m., 10 a.m., and 1 p.m. -08/14/12 at 7 a.m., 10 a.m., and 1 p.m. -08/17/12 at 3 a.m., 6 a.m., 9 a.m., and 1 p.m. -08/18/12 at 7 a.m., 10 a.m., 1 p.m., and 5:30 p.m. -08/20/12 at 7 a.m., 10 a.m., and 1 p.m. -08/21/12 at 7 a.m., 10 a.m. times 2, and 1 p.m. -08/22/12 at 3 a.m., 6 a.m., 9 a.m., and 1 p.m. -08/23/12 at 3 a.m., 6 a.m., 9 a.m., and 1 p.m. -08/24/12 at 3 a.m., 6 a.m., 9 a.m., and 1 p.m. -08/30/12 at 7 a.m., 10 a.m., and 1 p.m. -08/31/12 at 3 a.m., 6 a.m., 9 a.m., and 1 p.m.			

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	<p>Interview with the DON on 01/28/13 at 10 a.m., indicated the nurse did not administer the narcotics according to the physician's orders.</p> <p>3. Resident E's clinical record was reviewed on 01/28/13 at 3:30 p.m. and indicated Resident E had diagnoses which included, but were not limited to, anemia, dementia, hypertension, hip fracture, aphasia, osteoporosis, difficulty walking, malaise, and fatigue.</p> <p>The Physician's Recapitulation, dated August 2012, indicated Resident E was prescribed "Hydrocodone/APAP 5/325 mg take 1 tablet by mouth every 4 hours" and "Hydrocodone/APAP 5/325 mg take 1 tablet by mouth every 4 hours as needed." In September, October, November 2012, Hydrocodone/APAP was ordered "10/325 mg, take 1 tablet by mouth three times daily." Also ordered was "Hydrocodone/APAP 10/325 mg take 1 tablet by mouth every 4 hours as needed for pain."</p> <p>The Controlled Substance Record and the MAR's dated August 2012, indicated LPN #7 administered doses outside prescribed parameters on the following dates: -08/01/12 at 8 a.m., 10 a.m., 12 p.m.,</p>			

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	<p>and 2 p.m.</p> <p>-08/02/12 at 8 a.m., 10 a.m., and 1 p.m.</p> <p>-08/03/12 at 6 a.m., 9 a.m., 11 a.m., and 1 p.m.</p> <p>-08/06/12 at 8 a.m., 10 a.m., 12 p.m., and 2 p.m.</p> <p>-08/07/12 at 8 a.m., 10 a.m., and 1 p.m.</p> <p>-08/08/12 at 6 a.m., 9 a.m., and 12 p.m.</p> <p>-08/09/12 at 3 a.m., 5 a.m., 8 a.m., and 1 p.m.</p> <p>-08/10/12 at 3 a.m., 6 a.m., 9 a.m., 11 a.m., and 2 p.m.</p> <p>-08/11/12 at 8 a.m., 10 a.m., 12 p.m., 2 p.m., 4:30 p.m. and 6 p.m.</p> <p>-08/12/12 at 8 a.m., 10 a.m., 12 p.m., 2 p.m., and 5 p.m.</p> <p>-08/13/12 at 8 a.m., 10 a.m., 12 p.m. and 2 p.m.</p> <p>-08/14/12 at 8 a.m., 10 a.m., and 12 p.m.</p> <p>-08/15/12 at 6 a.m., 8 a.m., 10 a.m., and 12 p.m.</p> <p>-08/16/12 at 8 a.m., 10 a.m., and 1 p.m.</p> <p>-08/17/12 at 3 a.m., 6 a.m., and 9 a.m.</p> <p>-08/18/12 at 10 a.m., 3 p.m. and 5 p.m.</p> <p>-08/20/12 at 8 a.m., 10 a.m., 12 p.m., and 2 p.m.</p> <p>-08/21/12 at 8 a.m., 10 a.m., and 12 p.m.</p>			

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	<p>-08/22/12 at 3 a.m., 6 a.m., and 9 a.m.</p> <p>-08/23/12 at 3 a.m., 6 a.m., 9 a.m., and 11 a.m.</p> <p>-08/24/12 at 3 a.m., 6 a.m., and 9 a.m.</p> <p>-08/26/12 at 10 a.m., 2 p.m., 4 p.m., and 6 p.m.</p> <p>-08/27/12 at 8 a.m. and 9:30 a.m.</p> <p>Interview with the DON on 01/28/13 at 10 a.m., indicated the nurse did not administer the narcotics according to the physician's orders.</p> <p>4. Resident F's clinical record was reviewed on 01/28/13 at 4 p.m. and indicated Resident F had diagnoses which included, but were not limited to, pneumonia, hypertension, aphasia, cerebrovascular accident, depression, dysphagia, neuritis, muscle spasm, and chronic obstructive pulmonary disease.</p> <p>The Physician's Recapitulation, dated August 2012, indicated Resident F was prescribed Hydrocodone/APAP 5/325 mg 1 every 4 hours as needed, and Hydrocodone/APAP 10/325 mg. 1 three times a day (scheduled) and 1 every 4 hours as needed. The Controlled Substance Record and the MAR's, dated August 2012, indicated LPN #7 administered doses outside</p>			

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	<p>prescribed parameters on the following dates:</p> <p>-08/01/12 at 10 a.m. and 1 p.m.</p> <p>-08/02/13 at 10 a.m. and 1 p.m.</p> <p>-08/03/12 at 3 a.m., 6 a.m., 9 a.m., 12 p.m., and 2:30 p.m.</p> <p>-08/06/12 at 7 a.m., 10 a.m., and 1 p.m.</p> <p>-08/07/12 at 7 a.m., 10 a.m., and 1 p.m.</p> <p>-08/08/12 at 3 a.m., 6 a.m., 10 a.m., and 1 p.m.</p> <p>-08/09/12 at 3 a.m., 6 a.m., 10 a.m., and 1 p.m.</p> <p>-08/10/12 at 3 a.m., 6 a.m., 10 a.m., and 1 p.m.</p> <p>-08/11/12 at 10 a.m., 1 p.m., 3 p.m., and 5 p.m.</p> <p>-08/12/12 at 7 a.m., 10 a.m., 1 p.m., and 5 p.m.</p> <p>-08/13/12 at 10 a.m. and 1 p.m.</p> <p>-08/14/12 at 8 a.m., 10 a.m. and 1 p.m.</p> <p>-08/15/12 at 3 a.m., 6 a.m., and 9 a.m.</p> <p>-08/16/12 at 10 a.m. and 1 p.m.</p> <p>-08/17/12 at 3 a.m., 6 a.m., and 9 a.m.</p> <p>-08/20/12 at 10 a.m. and 1 p.m.</p> <p>-08/21/12 at 8 a.m. and 10 a.m.</p> <p>-08/23/12 at 3 a.m., 6 a.m., and 10 a.m.</p> <p>-08/24/12 at 3 a.m., 6 a.m., and 9 a.m.</p> <p>-08/26/12 at 8 a.m., 10 a.m., 1 p.m.</p>						

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	<p>and 5 p.m. -08/27/12 at 8 a.m. and 10 a.m. -08/28/12 at 3 a.m., 6 a.m., and 9 a.m. -08/29/12 at 3 a.m., 6 a.m., and 9 a.m. -08/30/12 at 10 a.m. and 1 p.m. -08/31/12 at 3 a.m., 6 a.m., 9 a.m. and 1 p.m.</p> <p>Interview with the DON on 01/28/13 at 10 a.m., indicated LPN #7 did not administer the narcotics according to the physician's orders.</p> <p>Interview with the Director of Nursing [DON] on 01/30/13 at 12 p.m., indicated LPN #7 was not writing on the back of the MAR when she gave a PRN medication and was not following policy and procedures.</p> <p>Review of the facility's undated policy on Drug Administration indicated, "Medications are administrated as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after sufficient information regarding the resident's condition and expected outcomes of medication therapy is known. The licensed nurse is aware of an indication for the resident</p>				

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	<p>receiving medication, usual dose, parameters and routes, contraindications, allergies, sensitivities, and side effects." The procedures indicated, "...Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations...Medications are administered in accordance with written orders of the attending physician...All current medications and dosage schedules,...are listed on the resident's medication administration record...Medications are administered within 60 minutes of scheduled time...When PRN medications are administered, the following documentation is provided: Date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection or application site. Complaints or symptoms for which medication was given. Results achieved from giving the dose and the time results were noted....."</p> <p>This federal finding is related to Complaint IN00121579 and Complaint IN00121609.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure assessment of pain interventions for 1 of 3 sampled residents and 3 of 3 residents in an expanded sample [Residents C, D, E, and F].</p> <p>Findings include:</p> <p>1. Review of Resident C's closed clinical record, on 01/25/13 at 12:40 p.m., indicated Resident C resided on Misty Lane West and had diagnoses which included, but were not limited to, pneumonia, chronic kidney disease, coronary artery disease, dysphagia, hypertension, multiple myeloma, peripheral neuropathy, anemia secondary to gastro-intestinal bleed, colitis, and history of congestive heart failure.</p> <p>The physician's recapitulation, dated August 2012, indicated Resident C was prescribed Hydrocodone/APAP (narcotic pain medication) 5/325 mg (milligrams) 1-2 tablets by mouth</p>	F000309	<p>It is the intent of this facility to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. 1. Action Taken a. Nurses in-serviced on pain assessment policy and pain assessment form. In-service includes MD notification, and nursing documentation of pain and pain non-medication interventions, side-effects of pain medication, discontinuance of non-used PRN medication orders. 2. Others Identified a. DON\designee completed a 100% audit of pain medication orders and PRN pain assessments. No findings. 3. Systems in Place a. DON\designee will audit residents for pain assessment documentation, and MD notification in CQI meeting. DON\designee will review the 24 hour report for any changes in condition, including and new pain management orders. Any findings will be immediately addressed. 4. Monitoring a.</p>	02/28/2013

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	<p>every 4-6 hours as needed for pain.</p> <p>The Controlled Substance Record indicated LPN #7 administered Hydrocodone/APAP 5/325 mg 2 tablets to Resident C 184 times during the months August - October 2012.</p> <p>Resident C's most recent quarterly Minimum Data Set [MDS] assessment, dated 09/13/12, indicated the resident was independent with cognitive skills for daily decision-making, received scheduled pain medication regimen, received PRN [as needed] pain medication, and had not experienced pain or hurting in the last 5 days.</p> <p>Resident C's Pain Management Assessments dated 09/07/12 and 10/01/12, indicated no scheduled pain regimen, received PRN pain medication, had pain or hurting in the last 5 days, had frequent pain in the last 5 days, rated his pain a "3" on a pain scale (0-10 pain scale), and described his pain as moderate. The assessment indicated, "Current + PRN pain meds controlling pain @ [at] this x [time]."</p> <p>Resident C's pain care plan, dated 06/11/12, indicated approaches which</p>		<p>DON\designee to discuss audits and 24 hour reports in the CQI meeting. Any findings will be discussed with Medical Director at quarterly QA meetings and/or as needed. b. At a minimum all residents will be assessed for pain management on a quarterly basis and these assessments will be reviewed at the CQI meeting. Any findings will be immediately addressed with the residents primary physician. Results of the quarterly assessments will be reviewed with the Medical Director at quarterly QA meetings, and/or as needed. 5. Date of Compliance: 2/28/2013</p>				

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	<p>included, but were not limited to, "...Monitor for signs of pain such as: grimacing, guarding, tachycardia, moaning, frequent position changes...Assess the residents level of pain...Provide a quiet calm environment...Attempt to make the resident as comfortable as possible...Offer therapeutic massage of the painful area...Attempt other interventions such as: guided imagery, meditation, massage, ice/heat and focused breathing...Offer pain medication as ordered...Document effectiveness of approaches." The only approach used which was documented was pain medication as ordered.</p> <p>Interview with the Director of Nursing [DON] on 01/30/13 at 12 p.m., indicated she was not aware of the volume of pain medications signed out for Resident C and had not completed a new pain assessment based on the volume of pain medications signed out for the resident.</p> <p>2. Resident D's clinical record was reviewed on 01/28/13 at 3 p.m. and indicated Resident D had diagnoses which included, but were not limited to, dementia, anemia, hypertension, hyperlipidemia, diabetes, urinary tract</p>			

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	<p>infection, and hypothyroidism.</p> <p>The physician's recapitulation, dated August 2012, indicated Resident D was prescribed Oxycodone/APAP (narcotic pain medication) 5/325 mg 1-2 tablets by mouth every 4-6 hours as needed for pain. The physician's recapitulations, dated September, October, and November 2012, indicated Resident D was prescribed Oxycodone/APAP 5/325 mg 1-2 tablets by mouth every 4 hours as needed.</p> <p>The Controlled Substance Record indicated LPN #7 administered Oxycodone/APAP 5/325 mg 2 tablets to Resident D 586 times during August, September, October, and November 2012.</p> <p>Resident D's most recent quarterly MDS assessment dated 01/03/13 indicated the resident received PRN pain medication and rarely had pain in the last 5 days. Resident D rated her pain a "5" on a 0-10 scale. The nurse's notes lacked documentation of a pain assessment during the months of August - November 2012. The back of the Medication Administration Record's [MAR's] for August, September, and October, 2012 lacked documentation for each</p>				

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	<p>medication administration given by LPN #7.</p> <p>Interview with the Director of Nursing [DON] on 01/30/13 at 12 p.m., indicated she was not aware of the volume of pain medications signed out for Resident D and had not completed a new pain assessment based on the volume of pain medications signed out for the resident.</p> <p>3. Resident E's clinical record was reviewed on 01/28/13 at 3:30 p.m. and indicated Resident E had diagnoses which included, but were not limited to, anemia, dementia, hypertension, hip fracture, aphasia, osteoporosis, difficulty walking, malaise, and fatigue.</p> <p>The physician's recapitulations, dated August, 2012, indicated Resident E was prescribed Hydrocodone/APAP 5/325 mg 1-2 tablets by mouth every 4 hours as needed. The physician's recapitulations, dated September, October, and November, 2012, indicated Resident E was prescribed Hydrocodone/APAP 10/325 mg 1 tablet by mouth every 4 hours as needed for pain. The record indicated the reason for increased pain medication due to lower dose</p>				

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	<p>was not relieving pain effectively and the resident had hip surgery.</p> <p>Resident E's most recent quarterly MDS assessment dated 11/22/12, indicated the resident received both scheduled and PRN pain medications. All other pain assessments were blank.</p> <p>Resident E's clinical record had Pain Management Assessments dated 09/01/12 and 09/07/12. Both assessments indicated the resident received PRN pain medication and indicators of pain were non-verbal sounds and facial expressions with frequency observed daily.</p> <p>The Controlled Substance Record indicated Resident E received 179 tablets of prn (as needed) Hydrocodone/APAP 5/325 mg or 10/325 mg to Resident E during August, September, October, and November, 2012.</p> <p>Interview with the Director of Nursing [DON] on 01/30/13 at 12 p.m., indicated she was not aware of the volume of pain medications signed out for Resident E and had not completed a new pain assessment based on the volume of pain medications signed out for the</p>			

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	<p>resident.</p> <p>4. Resident F's clinical record was reviewed on 01/28/13 at 4 p.m. and indicated Resident F had diagnoses which included, but were not limited to, pneumonia, hypertension, aphasia, cerebrovascular accident, depression, dysphagia, neuritis, muscle spasm, and chronic obstructive pulmonary disease.</p> <p>The physician's recapitulations, dated 08/01/12, indicated Resident F's medications included, but were not limited to, Hydrocodone/APAP 5/325 mg 1 every 4 hours as needed and Hydrocodone 10/325 mg 1 three times a day (scheduled) and 1 every 4 hours as needed.</p> <p>The Controlled Substance Record indicated Resident F received 224 tablets of prn (as needed) Hydrocodone/APAP 5/325 mg or 10/325 mg during August, September, October, and November, 2012.</p> <p>Resident F's most recent quarterly MDS assessment dated 01/09/13 indicated the resident received scheduled and PRN pain medications. The rest of the resident's pain assessment indicated</p>				

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	<p>the resident was unable to answer. Only 1 Pain Management Assessment, dated 10/13/12, was found in the clinical record. The assessment indicated the resident received a scheduled and a PRN pain medication and indicators were non-verbal sounds, facial expressions, and protective body movements or postures. The frequency of indicators of pain were observed daily. The assessment indicated, "Current Fentanyl [sic] Patch et [and] PRN Norco unable to control all pain it appears according to res. [resident] expressions."</p> <p>Interview with the Director of Nursing [DON] on 01/30/13 at 12 p.m., indicated she was not aware of the volume of pain medications signed out for Resident F and had not completed a new pain assessment based on the volume of pain medications signed out for the resident.</p> <p>Review of the facility's policy for Pain Assessment and Management dated 02/28/12 indicated, "It is the intent of this facility that all residents will be assessed for pain at the time of admission, re-admission,, with any addition or change in routine pain medication and as needed." The</p>			

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	<p>procedure indicated, "... Complete a Pain Management Assessment form upon admission, readmission, with any addition or change of routine pain medication, and as needed to identify those residents on a routine basis who may require a modification in their pain management program...Non-medication pain management interventions must be considered prior to the administration of medication...Residents who receive a PRN pain medication will be assessed for the effectiveness...Document the results of the PRN pain medication on the back of the MAR and contact the physician if needed...."</p> <p>This federal finding is related to Complaint IN00121579 and Complaint IN00121609.</p> <p>3.1-31(a)</p>						

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F000425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to ensure their pharmacy services provided services to develop, implement, and evaluate a system to prevent narcotic diversion for 1 of 3 residents in a sample of 3 and for 3 of 3 residents in an expanded sample reviewed for missing narcotics. [Resident C, D, E, and F]</p> <p>Findings include:</p> <p>During an interview on 01/28/13 at 9:50 a.m., the Assistant Director of Nursing [ADON], indicated a large</p>	F000425	<p>It is the intent of this facility to ensure pharmacy services are provided to develop, implement, and evaluate a system to prevent narcotic diversion. 1. Action Taken a. Pharmacy in conjunction with facility reviewed\amended narcotic policy. b. Pharmacy consultant will have exit visit with DON\designee after each monthly visit and as needed. 2. Others Identified a. 100%audit of all PRN narcotic orders and PRN MAR documentation. 3. Systems in Place a. Any concerns found by pharmacy consultant during monthly visit will be addressed immediately. b.</p>	02/28/2013			

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	<p>volume of Hydrocodone-Oxycodone (narcotic pain medication) tablets were discovered missing from residents' medication supplies during November 2012.</p> <p>During an interview on 01/28/13 at 10 a.m., the Director of Nursing [DON] indicated 11, 549 doses of narcotics prescribed for residents on the Misty Lane West hall were missing from the medication cart between August-November 2012. The DON indicated there were no alerts of high volumes of pain medications being signed out for Residents C, D, E and F from the pharmacy consultant that completed monthly reviews of each residents' medications.</p> <p>A facility "Incident Report," dated 11/17/12, indicated Oxycodone (narcotic pain medication) was missing from residents' medication supplies.</p> <p>During an interview, on 01/30/13 at 3:43 p.m., the Pharmacy Consultant for the facility indicated each resident's medications were reviewed for appropriateness, monitoring of labs, and, depending on the month, medication timing. The Pharmacy Consultant indicated spot checks of medication carts, narcotic counts, and</p>		<p>The PRN Controlled Drug Receipt\Record Disposition Form will be audited 5 times per week for four weeks, then audited 3 times per week, and then ongoing on a one time per week basis to ensure that medications are being administered per physician order. c. As a further deterrent for drug diversion, the packing slip from the pharmacy has been amended to ensure that medications delivered to the facility are accurate and accurately reflect the physician's order. 4. Monitoring a. Any issues identified will be immediately addressed and will be discussed in the daily CQI meeting. Any findings will be discussed with the Medical Director at quarterly QA meeting and/or as needed. b. Narcotic report, which is received from pharmacy weekly by DON\designee will be compared to packing slips on an ongoing basis to ensure accuracy of medications delivered. 5. Date of Compliance: 2/28/2013</p>		

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NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
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	<p>MAR documentation were also done. The Pharmacy Consultant indicated all resident's charts were gone through once a month and any recommendations were sent to the DON to address with the physician.</p> <p>Review of the facility's policy for pharmacy's controlled substances, dated 06/19/12, indicated, "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations." The procedure indicated, "...Only authorized nursing personnel and pharmacy personnel have access to control drugs. The Director of Nursing is responsible for the control of these medications...At each shift change, a physical inventory of specific medications, those selected by the facility, is conducted by two licensed nurses and is documented on an audit record....Current controlled medication accountability records and audit records are kept in the MAR [Medication Administration Record] or other specific binder. When completed, audit and accountability records are submitted to the director</p>			

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	<p>of nursing and kept on file according to facility policy for health records retention....Any discrepancy in controlled substance medication counts is reported to the Director of Nursing immediately. The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. Irreconcilable discrepancies are documented by the Director of Nursing and reported to the Consultant Pharmacist and Administrator. The Administrator, Pharmacist, and the Director of Nursing will make a determination concerning of any actions that may need to be taken."</p> <p>An untitled policy, dated 06/19/12, indicated, "Policy: Regular Consultant Pharmacist services are provided to residents for nursing facilities that have a written agreement for such services." The Procedures indicated, "The Consultant Pharmacist agrees to render the required services in accordance with local, state, and federal laws, regulations, and guidelines facility: policies and procedures; and community standards of practice....The Consultant Pharmacist, or adjunctive licensed pharmacy personnel under</p>			

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	<p>the control of the Consultant Pharmacist, provides consultant pharmacist services, including but not limited to the following: ... The operational pharmacist reviews the physician order at the time of receipt and compares the order with the patient profile and additional information as described above for: appropriate drug for indication (diagnosis), therapeutic duplication, appropriate dosage, potential... contraindications, appropriate dosing schedule...Review a sample of medication administration records (MARs) and physicians orders to assure proper documentation of the medication orders and administration of medications to residents...Assisting the administrator and Pharmaceutical Services Committee in setting standard and developing, implementing, and the monitoring policies and procedures for the safe and effective distribution, control and use of medications...and services in the facility...."</p> <p>This federal finding is related to Complaint IN00121579 and Complaint IN00121604.</p> <p>3.1-25(e)(1) 3.1-25(e)(2) 3.1-25(e)(3)</p>						

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