

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2013
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NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011
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F000000	<p>This visit was for the Investigation of Complaint IN00136430.</p> <p>Complaint IN00136430 - Substantiated. Federal/State findings related to the allegations are cited at F221, F309, and F514.</p> <p>Survey date: September 30, 2013 and October 1, 2013</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 135 SNF: 27 Total: 162</p> <p>Census payor type: Medicare: 21 Medicaid: 122 Other: 19 Total: 162</p> <p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410</p>	F000000	<p>October 29, 2013 Long Term Care Division, 4th Floor2 North Meridian StreetIndianapolis, IN 46204 RE: ManorCare Health Services of Anderson 1345 N. Madison Ave. Anderson, IN 46011Dear Kim Rhoades: Please note our Plan of Correction and allegation of compliance for the Recertification and State Licensure Survey completed on November 2, 2013. We respectfully request a desk review. Should you have any other questions or need additional information, please contact me at the above address or phone number. You may also contact me via email at 421admin@hcr-manorcare.com. Sincerely, Nicole Fields, HFAdministrator</p>	

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

TITLE

(X6) DATE

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

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	IAC 16.2.  Quality review completed by Debora Barth, RN.				

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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident observed with a seat belt restraint had orders for the restraint and failed to ensure restraint release monitoring was being completed for 1 of 1 resident reviewed who was unable to self release his seat belt in a sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>During an observation on 9/30/13 at 12:15 p.m., Resident #D was up in his reclining wheelchair in the hall next to the Family Tree nursing station. The resident was very thin with severe contractions noted of the upper and lower extremities. A seat belt restraint was closed around the resident's waist.</p> <p>The clinical record for Resident #D was reviewed on 9/30/13 at 12:20 p.m.</p> <p>Diagnoses for the resident included,</p>	F000221	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident D record was reviewed, assessment completed and updated to reflect resident no longer utilizes seatbelt while up in the electric wheelchair. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; A chart review completed to identify other residents having the potential to be affected by the same deficient practice. All residents that utilize seatbelts in electric wheelchairs have been reviewed. All can remove seatbelts without assistance, have current orders that they may utilize the seatbelt while up in their electric wheelchair, care plans and tasks have been updated. Please see attachment A. The Director of Care Delivery or designee will complete a review of all residents that utilize seatbelts to ensure they are capable of self-releasing. Findings will be presented to QAA for review. What measures will be put into place or what systemic</p>	11/02/2013	

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	<p>but were not limited to, cerebral palsy with chronic contractures of the upper and lower extremities, chronic obstructive pulmonary disease, tracheostomy, and cachexia with gastrostomy tube placement.</p> <p>A significant change minimum data set assessment, dated 8/22/13, indicated the resident was severely cognitively impaired, incontinent of bowel and bladder, and required extensive assistance from the staff for all activities of daily living.</p> <p>A current health care plan problem, dated 12/23/10 with a new target date of 12/29/13, indicated the resident required the use of a seat belt when up in wheelchair for positioning and safety related to cerebral palsy and muscle spasms. One of the approaches for this problem was for the staff to "use safety device, seat-belt, when in wheelchair per physician's orders."</p> <p>The clinical record lacked any physician's order for the use of the seat belt safety device.</p> <p>LPN #1 was interviewed on 9/30/13 at 12:30 p.m. Information was requested related to the lack of any physician's order for the seat belt</p>		<p>changes will be made to ensure that the same deficient practice does not recur; RN/LPN staff will be educated on the Restraint Guidelines. Please see attachment B. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place; The Director of Care Delivery or designee will complete an audit at least five times per week to ensure residents can self-release seatbelts; in addition ensure compliance with the restraint guidelines. Please see attachment C. Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p>		

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	<p>restraint and whether the resident could release the seat belt restraint by himself. LPN #1 reviewed the clinical record and indicated she was unable to find an order for the seat belt. She indicated the resident had severely contracted hands and he was not able to release the seat belt himself. She indicated the facility had not considered the seat belt a restraint since it was used as a safety device and no restraint release records had been maintained during it's use.</p> <p>Review of the current "Restraint Practice Guide", dated 5/2009, provided by the DoN on 10/1/13 at 2:05 p.m., included, but was not limited to, the following:</p> <p>"Initial Evaluation</p> <p>... Review history, symptoms, diagnostic findings, results of alternative interventions trials, and medical evaluation with the physician...</p> <p>Obtain a physician's order for the restraint</p> <p>...On-going management strategies</p> <p>...The nursing assistant works in</p>			

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	<p>conjunction with the licensed nurse to ensure restraint does not interfere with activities of daily living. The nursing assistant releases the restraint and assists the patient to redistribute weight at least every two hours or as indicated by individual patient need.</p> <p>Documentation is completed per the center protocol...."</p> <p>This federal tag relates to Complaint IN00136430.</p> <p>3.1-26(b) 3.1-26(f)</p>				

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F000309 SS=D	<p><b>483.25</b>  <b>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  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 observation, interview, and record review, the facility failed to ensure a resident was monitored for bowel related problems and respiratory related problems following his readmission from the hospital for treatment of pneumonia and a bowel obstruction for 1 of 3 residents reviewed for bowel and/or respiratory services in a sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>During an observation on 9/30/13 at 12:15 p.m., Resident #D was up in his reclining wheelchair in the hall next to the Family Tree nursing station. The resident had a stoma opening in his neck from a previous tracheostomy. There were thin clear secretions at the bottom of the stoma opening. The resident was very thin with severe contractions noted of the upper and lower extremities.</p> <p>The clinical record for Resident #D</p>	F000309	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The medical record for resident D was reviewed and updated to reflect the resident's current condition. Resident D is currently free from signs and symptoms of constipation and Bowel status is reviewed daily by Nursing. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; A chart review was completed to identify other residents having the potential to be affected by the same deficient practice. Audits included residents identified with a change in condition. Change in condition may include but is not limited to signs and symptoms of lack of BM x 3 days or greater and/or change in condition from recent hospitalization. Residents identified with change in condition reflex assessment and MD notification. Please see attachment D. The Director of Care Delivery or designee will</p>	11/02/2013	

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	<p>was reviewed on 9/30/13 at 12:20 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, cerebral palsy with chronic contractures of the upper and lower extremities, chronic obstructive pulmonary disease, tracheostomy, and cachexia with gastrostomy tube placement.</p> <p>A significant change minimum data set assessment, dated 8/22/13, indicated the resident was severely cognitively impaired, incontinent of bowel and bladder, and required extensive assistance from the staff for all activities of daily living.</p> <p>A current health care plan problem, dated 12/23/10 with a new target date of 12/29/13, indicated the resident had problems with constipation related to lack of exercise. The goal for this problem was for the resident to have a bowel movement at least every 3 days. Approaches for this problem included, but were not limited to:</p> <p>"Administer medications per physician order and monitor effectiveness.</p> <p>"Monitor and report any signs and symptoms of constipation such as</p>		<p>complete a review of the 24 hour report sheet and orders to monitor for acute change in condition and completion of pertinent documentation. The Director of Care Delivery or designee will complete a review of all residents Bowel Movement status to ensure timely follow up if residents triggers for no BM in 3 days and documentation of clinical assessment. Findings will be presented to QAA for review. Please see attachment E. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur; RN/LPN staff will be educated on the guidelines for monitoring for acute change in condition related to recent admission or readmit from hospital stay to include pertinent documentation and physician notifications. Please see attachment F. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place; The Director of Care Delivery or designee will complete a review of the 24 hour report sheet and orders to monitor for acute change in condition and completion of pertinent documentation. at least five times per week. Please see attachment G. The Director of Care Delivery or designee will complete a review of all residents</p>		

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	<p>abdominal cramping, diarrhea, nausea and vomiting, and no BM [bowel movement] for 3 days."</p> <p>A current health care plan problem, dated 7/30/13 and revised on 8/16/13, indicated Resident #D was at risk for respiratory impairment related to aspiration and pneumonia. Approaches for this problem included, but were not limited to:</p> <p>"Monitor for and report adverse changes in respiratory rate, cough, respiratory effort, and sputum color/consistency.</p> <p>" Administer medications/treatments per physician orders and monitor for effectiveness/side effects."</p> <p>Physician's orders, dated 7/3/13, indicated the resident's trach cannula could be left out and routine stoma care was ordered.</p> <p>Bowel records for Resident #D indicated he had a bowel movement daily from August 1 through August 5, 2013.</p> <p>A nursing note, dated 8/5/13 at 10:55 a.m., indicated "Resident grimacing and scared. O2 sats [oxygen saturation level] at 90%. Nurse</p>		<p>Bowel Movement status to ensure timely follow up if residents triggers for no BM in 3 days and documentation of assessment at least five times per week. Please see attachment H. Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p>				

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	<p>suctioned resident and encourage coughing. Resident produced copious amounts of mucus which was suctioned. O2 sats returned to 97%. Resident smiling again. Will continue to monitor." This was the only nursing note dated 8/5/13.</p> <p>An "Acute Care Transfer" report, dated 8/5/13 at 2:43 p.m., indicated the resident's O2 sat was 88% on room air. The transfer report indicated the resident was having problems with the respiratory system (noted by a checkmark in a box) and had an additional comment of "vomiting". The resident was transferred to the hospital for treatment.</p> <p>A hospital discharge summary, dated 8/10/13, indicated the resident had been treated for aspiration pneumonia with intravenous (IV) antibiotic therapy. The summary also indicated a fecal impaction had been noted upon x-ray at the hospital (the date of the x-ray was not provided) and treatment was given with the follow-up x-ray showing resolution of the impaction. The summary indicated the resident was being discharged back to the nursing home on continued IV antibiotic treatment and medications ordered to help</p>			

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	<p>prevent and/or resolve constipation.</p> <p>A nursing note, dated 8/10/13 at 10:34 p.m., indicated the resident had been readmitted back to the nursing home at 5 p.m. The note indicated "wheezes heard upon auscultation" and "O2 [sat] at 97%". The note indicated the resident was on an IV antibiotic for pneumonia and had a peripheral IV in his right arm.</p> <p>A Readmission Screen report, dated 8/10/13 at 7:26 p.m., included the same information as noted previously in the 8/10/13, 10:34 p.m. nursing note.</p> <p>The clinical record contained no other nursing notes, vital sign information, O2 saturation levels, and/or assessment information of any type from 8/10/13 at 10:34 p.m. through 8/13/13 at 11:14 a.m..</p> <p>The bowel records for Resident #D indicated the resident had a small soft bowel movement on 8/12/13. The records indicated the resident did not have any bowel movements from 8/13/13 through 8/19/13. This indicated a time period of 7 days without a bowel movement following hospital treatment for a fecal impaction. The clinical record lacked</p>			

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	<p>any information related to the resident receiving the Dulcolax suppository 10 milligrams rectally which was ordered to be given as needed for constipation. The nursing notes for this time period lacked any assessment by the nursing staff related to the lack of bowel movements.</p> <p>The Administrator and Director of Nursing (DoN) were interviewed on 10/1/13 at 12:10 p.m. Additional information was requested related to the lack of assessment and monitoring of the residents respiratory status following his return from the hospital on 8/10/13 thru 8/13/13. Information was also requested related to the lack of abdominal assessment and interventions being provided as ordered by the physician during the 7 day time period without a bowel movement being recorded.</p> <p>The DoN was interviewed on 10/1/13 at 2:10 p.m. She indicated she had no additional information to provide related to the lack of assessment, monitoring, and interventions provided for the concerns noted above.</p> <p>Review of the current facility policy, dated 8/11/06, provided by the DoN</p>			

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	<p>on 10/1/13 at 2:05 p.m., titled "Charting: Alert", included, but was not limited to, the following:</p> <p>"Purpose: To provide a guideline for the clinical documentation process that may be needed following a change in patient condition or status.</p> <p>Guideline: The alert charting process included documentation of a patient's condition that warrants alert charting, the decisions and actions of staff related to the patient's condition and the patient's response to interventions implemented.</p> <p>Situations for alert charting typically include new admission monitoring needs, acute change of patient condition or situations that are expected to resolve or stabilize within 14 days. Some examples may include, but are not limited to:</p> <p>change in condition... new admissions or re-admissions signs and symptoms of infection...</p> <p>Documentation for alert charting occurs each shift for a minimum of 72 hours.</p> <p>...Documentation related to the alert charting process may include, but is</p>			

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	<p>not limited to, patient evaluation pertinent to the condition identified as the acute event vital signs..."</p> <p>This federal tag relates to Complaint IN00136430.</p> <p>3.1-37(a)</p>			

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented for 3 of 4 resident's reviewed for documentation of medication administration, dismissal to home, and/or contact with the physician in a sample of 4. (Resident #'s C, B, and E)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #C was reviewed on 9/30/13 at 3 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, hyperlipidemia and renal insufficiency.</p> <p>A lab test, dated 8/20/13, indicated</p>	F000514	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The medical record for resident C was reviewed and currently reflects documentation that resident is receiving medications per physician orders. The medical record for resident E was reviewed and currently reflects documentation that resident is receiving medications per physician orders. Resident B no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; A chart review completed to identify other residents having the potential to be affected by the same deficient practice. Residents that have potential for discharge and</p>	11/02/2013			

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	<p>the resident's triglyceride level was elevated and a notation on the test indicated the physician was notified. A physician's order, dated 8/22/13, indicated a new order had been received for Livalo (a medication given to help lower the triglyceride level) 2 milligrams (mg) daily at bedtime.</p> <p>A Nurse Practitioner (NP) order, dated 9/9/13, indicated "**Clarification* Livalo 2 mg tab 1 qhs [every bedtime] (Please Send!!!)" The nursing notes lacked any information related to this order.</p> <p>The clinical record lacked any documentation of this medication having been given following the order on 8/22/13 through 9/11/13.</p> <p>The clinical record lacked any nursing notes for August 2013.</p> <p>The DoN was interviewed on 9/30/13 at 4:00 p.m. Additional information was requested related to the two orders for the Livalo medication and the lack of documentation of it having been given as ordered.</p> <p>The DoN was interviewed on 10/1/13 at 9:10 a.m. She indicated she had talked to LPN #2 about the Livalo</p>		<p>receive medications have the potential to be affected by this same practice. Please see attachments I and J. The Director of Care Delivery or designee will complete a review daily of residents that are to be discharged from the facility to ensure there is appropriate documentation at the time of discharge. The Director of Care Delivery or designee will complete medication pass observations each shift to ensure proper documentation and follow up is in place. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur; RN/LPN will be educated on the Medication Administration guidelines to include ensuring residents receive the medication as ordered and any pertinent documentation. Please see attachment K. RN/LPN will be educated on appropriate documentation in the clinical record for residents discharging from the facility. Please see attachment K. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place; The Director of Care Delivery or designee will complete six Medication Administration observations a week for four weeks with findings presented weekly to the QAA</p>		

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	<p>orders. She indicated the pharmacy did not fill the order on 8/22/13 and requested clarification because the resident was already on Pravastatin sodium 40 mg tab 1 at bedtime daily for hyperlipidemia. A copy of this request was reviewed. The DoN indicated LPN #2 called the resident's physician regarding the pharmacy request for clarification and was told to hold the Livalo medication until the physician saw the resident the next week and he would decide whether to change or continue medications at that time. LPN #2 did not write any phone order or make any nursing note entry regarding this conversation with the physician and could not remember what date she had made the call.</p> <p>The DoN indicated LPN #2 told her the resident was seen by the physician on 9/3/13 and an order was received to "Stop Simvastatin (another medication given for hyperlipidemia)", but no order was received to begin the Livalo medication. The pharmacy again requested clarification because the resident was not on Simvastatin, but was on Pravastatin for hyperlipidemia which is a different medication. The order was clarified by the NP on 9/9/13 for the resident to get the</p>		<p>committee for review. Please see attachment L. The Director of Care Delivery or designee will complete a review of all residents discharged from the facility to ensure there is appropriate documentation in the medical record. Please see attachment M. Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p>				

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	<p>Livalo medication as ordered (and continue on the Pravastatin).</p> <p>The nursing notes for August and September 2013 lacked any info related to the medication being ordered, being held, contact with the pharmacy, and/or contact with the physician.</p> <p>The DoN indicated this information should have all been documented when the events occurred.</p> <p>2.) The clinical record for Resident #E was reviewed on 10/1/13 at 10:00 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, multiple sclerosis, seizure disorder, and history of pulmonary embolism.</p> <p>A recapitulation of physician's orders, dated 9/2/13, indicated the resident had medication orders which included, but were not limited to, the following:</p> <p>Zonisamide (an antiseizure medication) 100 mg tabs 2 (200 mg) every morning Zonisamide 100 mg tabs 3 (300 mg) every evening at bedtime Coumadin (a blood thinner) 3 mg tab</p>						

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	<p>1 at 5 p.m. Coumadin 4 mg tab 1 at 5 p.m. (total dose 7 mg) Advair Diskus inhaler- 1 puff by mouth twice daily at 8 a.m. and 4 p.m.</p> <p>The September Medication Administration Record (MAR) for 2013 lacked documentation of these medications being given on the following dates and times:</p> <p>Zonisamide 100 mg tabs 3 at bedtime-Not documented on 9/3/13, 9/5/13, 9/11/13, 9/12/13, and 9/29/13. Zonisamide 100 mg tabs 2 every a.m. -Not documented on 9/29/13 Coumadin 3 mg tab 1 at 5 p.m.- Not documented on 9/2/13, 9/16/13, and 9/17/13. Coumadin 4 mg tab 1 at 5 p.m.- Not documented on 9/2/13, 9/16/13, and 9/17/13. Advair Diskus inhaler at 4 p.m. daily - Not documented on 9/2/13, 9/25/13, 9/26/13, 9/27/13, 9/28/13, and 9/29/13.</p> <p>The clinical record lacked any information related to these medications having not been given.</p> <p>The DoN was interviewed on 10/1/13 at 12:10 p.m. regarding the lack of documentation of the above noted</p>						

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	<p>medications having been given.</p> <p>The DoN was interviewed on 10/1/13 at 2:10 p.m. She provided a written statement from Resident #E related to an interview done with the resident by RN #3. The statement indicated the resident felt she had not missed any of her medication. The DoN indicated the resident readily spoke up for herself and she felt the concern was documentation errors.</p> <p>3.) The clinical record for Resident #B was reviewed on 9/30/13 at 2 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, cerebral palsy and seizure disorder.</p> <p>Admission orders for Resident #B, dated 8/26/13, indicated the resident had an order for Oxcarazepine 300 mg tabs 2 (600 mg) twice daily at 8 a.m. and 8 p.m.</p> <p>The September Medication Administration Record (MAR) for 2013 lacked documentation of the Oxcarazepine medication having been given on 9/8/13 at 8 p.m.</p> <p>The nursing notes lacked any information related to the medication having not been given.</p>						

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	<p>A home discharge instruction sheet, dated 9/10/13 (no time noted), indicated the resident was dismissed to home on that date.</p> <p>The clinical record lacked any nursing notes for 9/9/13 or 9/10/13.</p> <p>The DoN was interviewed on 10/1/13 at 10:20 a.m. related to the lack of dismissal information in the nursing notes and the medication not documented on 9/8/13.</p> <p>During an interview on 10/1/13 at 2:10 p.m., the DoN indicated she had no additional information to provide.</p> <p>4.) Review of the current facility policy, dated 3/2010, provided by the DoN on 10/1/13 at 2:05 p.m., titled "Medication Administration: Medication Pass", included, but was not limited to, the following:</p> <p>"Purpose: To safely and accurately prepare and administer medication according to physician order and patient needs....</p> <p>Procedure:</p> <p>...9. Administer medication</p>				

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	<p>...*administer medication according to specific procedure such as oral, topical, injection, etc. ...*document initials on MAR for each medication administered."</p> <p>This federal tag relates to Complaint IN00136430.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			