

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/06/2014
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NAME OF PROVIDER OR SUPPLIER  WATERS OF NEW CASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N 16TH ST NEW CASTLE, IN 47362
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F000000	<p>This visit was for the Investigation of Complaint IN00153582.</p> <p>Complaint IN00153582 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F425 and F514.</p> <p>Survey dates: August 4, 5 and 6, 2014</p> <p>Facility number: 000201 Provider number: 155304 AIM number: 100267910</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 3 SNF/NF: 44 Total: 47</p> <p>Census payor type: Medicare: 13 Medicaid: 24 Other: 10 Total: 47</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>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 August 30, 2014.</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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F000282 SS=D	<p>Quality review completed on August 15, 2014 by Cheryl Fielden, RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to notify a resident's attending physician when a medication was unavailable from the contracted pharmacy within 3 days of admission and/or when a resident failed to receive 2 or more consecutive doses of a medication. This deficient practice affected 1 of 3 residents reviewed for medication administration in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 8-4-14 at 2:25 p.m. Her diagnoses included, but were not limited to, C-2 to T-2 (neck and upper back area) fusion with laminectomy, cervical spondylosis, rheumatoid arthritis, anxiety, altered mental status, fall on 4-13-14 resulting in right femur fracture</p>	F000282	<p>F282 It is the intent of this facility to ensure physician notification is made related to a medication being unavailable from the contracted pharmacy within 3 days of admission and/or when a resident fails to receive 2 or more consecutive doses of a medication. 1-Corrective action for affected resident; Resident #A is no longer in the facility. 2-Other residents with potential to be affected; -audit completed for all residents current MAR with notification made as needed. 3-Measures to prevent reoccurrence; -Inservice on 8/13/14 for licensed nurses and QMA's re: Medication Administration Procedure. -DON/designee to review the MAR and clinical record 3 times a week for 2 months then 2 times a week for 2 months then weekly for 2 months to ensure physician notification is completed for medications not administered per policy. 4-Monitoring of corrective</p>	08/30/2014

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	<p>with surgical repair, acute and chronic pain, severe vitamin D deficiency and COPD (chronic obstructive pulmonary disease). The clinical record indicated she was originally admitted to the facility on 4-12-14 and was there for less than 24 hours and then returned to the facility on 4-19-14.</p> <p>In review of the readmission physician orders, dated 4-19-14, it indicated she was to receive the following medications: -Combivent (a bronchodilator) 18 mcg (micrograms)-103 mg (milligrams) 2 puffs four times daily by mouth via meter-dosed inhaler. -Premarin (estrogen) 0.625 mg daily by mouth. -Xarelto (an anticoagulant) 10 mg daily by mouth.</p> <p>In review of the MAR (Medication Administration Record) for 4-19-14 until discharge on 4-22-14, it indicated the Combivent 18-mcg-103 mg was not administered. Each identified dosage was indicated to have encircled staff initials. There was no indication listed on the back of the MAR or in the nursing progress notes as to why the medication was not administered. Review of the "Packing Slip" from the contracted pharmacy service indicated this medication was not received on the</p>		<p>action to ensure the practice will no recur; -DON/designee will complete a monthly summary audit to be presented to the monthly QA committee with the Administrator related to documentation and physician notification for medications not administered. This monthly summary will again be presented to the Quarterly QA committee with the Administrator and Medical Director. 5-Date the systematic changes will be completed and who will be responsible; -DON/designee will be responsible for on-going compliance. Date of Compliance 8/30/2014.</p>	

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	<p>deliveries of late 4-20-14 or early 4-22-14. This medication was not identified to be available in the facility's emergency drug kit (EDK). Documentation did not indicate the resident's attending physician was notified of the facility's inability to obtain the medication and resulting inability to administer the medication.</p> <p>The MAR for 4-19-14 until discharge on 4-22-14, indicated the Premarin 0.625 mg doses due on 4-20-14 and 4-21-14 had encircled staff initials and the dosage for 4-22-14 was blank. There was no indication listed on the back of the MAR or in the nursing progress notes as to why the medication was not administered. Review of the "Packing Slip" from the contracted pharmacy service indicated 30 tablets of this medication were received on the delivery of early 4-22-14. This medication was not identified to be available in the facility's EDK. Documentation did not indicate the facility notified the physician of the resident not receiving the ordered medication.</p> <p>The MAR for 4-19-14 until discharge on 4-22-14, indicated each dosage of the Xarelto 10 mg was left blank. There was no indication listed on the back of the MAR or in the nursing progress notes as</p>				

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	<p>to why the medication was not administered. Review of the "Packing Slip" from the contracted pharmacy service indicated 21 tablets were received late evening on 4-20-14. This medication was not identified to be available in the facility's EDK. Documentation did not indicate the facility notified the physician of the resident not receiving the ordered medication.</p> <p>In an interview with the Director of Nursing on 8-6-14 at 10:17 a.m., she indicated she would expect any medications that were not administered and had the staff's initials circled on the MAR should have a reason to be documented on the back of the MAR.</p> <p>On 8-6-14 at 1:10 p.m., the Administrator provided a copy of a policy entitled, "Drug Administration-General Guidelines." This policy was indicated to be the current policy and had a revision date listed as 6-19-12. This policy indicated, "Medications are administered as prescribed, in accordance with good nursing principles and practices...If a dose of regularly scheduled medication is withheld [sic], refused, or given at other than the scheduled time (e.g., resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage</p>			

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	<p>administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation. If two consecutive doses of a medication are withheld [sic] or refused, the physician is notified..."</p> <p>On 8-6-14 at 1:10 p.m., the Administrator provided a copy of a policy entitled, "Procedure For Using Emergency Dispensing Kits." This policy was indicated to be the current policy and had a revision date listed as 1-27-14. This policy indicated, "An emergency supply of medications typically used for starter doses is maintained in the facility in limited quantities by the provider pharmacy in a portable, sealed container...The contents of the emergency dispensing kits are listed on the outside of the box. Lists will also be posted at each nursing station...Licensed nurses may utilize the emergency dispensing kits medications only after receiving an order; either written or oral, from the physician for the resident..."</p> <p>This Federal tag relates to Complaint IN00153582.</p> <p>3.1-35(g)(2)</p>						

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F000425 SS=D	<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.</p> <p>A. Based on record review and interview, the facility failed to ensure accurate documentation of medications not administered for 1 of 3 residents in a sample of 3 reviewed for medication administration had reasons cited as to why the medications were not administered as ordered by the physician. (Resident #A)</p> <p>B. Based on record review and interview, the facility failed to ensure accurate documentation of medication disposition upon discharge from the facility for 1 of 1 residents reviewed for medication disposition in a sample of 3.</p>	F000425	F 425 It is the intent of this facility to ensure accurate documentation of medications not administered as to why the medications were not administered as ordered by the physician. It is the intent of this facility to ensure accurate documentation of medication disposition upon discharge from the facility. 1-Corrective action for affected resident; Resident #A is no longer in the facility. 2-Other residents with potential to be affected; A-audit completed for all residents current MAR, documentation made as needed by the appropriate staff. B-use of pharmacy medication print out will	08/30/2014

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	<p>(Resident #A)</p> <p>Findings include:</p> <p>A. Resident #A's clinical record was reviewed on 8-4-14 at 2:25 p.m. Her diagnoses included, but were not limited to, C-2 to T-2 (neck and upper back area) fusion with laminectomy, cervical spondylosis, rheumatoid arthritis, anxiety, altered mental status, fall on 4-13-14 resulting in right femur fracture with surgical repair, acute and chronic pain, severe vitamin D deficiency and COPD (chronic obstructive pulmonary disease). The clinical record indicated she was originally admitted to the facility on 4-12-14 and was there for less than 24 hours and then returned to the facility on 4-19-14.</p> <p>In review of the readmission physician orders, dated 4-19-14, it indicated she was to receive the following medications:</p> <ul style="list-style-type: none"> <li>-Combivent (a bronchodilator) 18 mcg (micrograms)-103 mg (milligrams) 2 puffs four times daily by mouth via meter-dosed inhaler.</li> <li>-Premarin (estrogen) 0.625 mg daily by mouth.</li> <li>-Neurontin (an anticonvulsant that can used for neuralgia or chronic pain) 300 mg twice daily by mouth.</li> <li>-Xarelto (an anticoagulant) 10 mg daily</li> </ul>		<p>no longer be utilized independently but will be attached to a discharge form completed by the licensed nurse which includes the medication count. 3-Measure to prevent reoccurrence:</p> <p>A-1-Inservice completed for licensed nurses and QMA's re: Medication Administration Procedure 8/13/2014.</p> <p>A-2-DON/designee to review the MAR and clinical record 3 times a week for 2 months then 2 times a week for 2 months then weekly for 2 months to ensure documentation is completed for medications not administered.</p> <p>B-1-Inservice completed for licensed nurses re: Post discharge to home instructions.</p> <p>B-2-DON/designee to review the post discharge to home instructions 3 times a week for 2 months then 2 times a week for 2 months the weekly for 2 months to ensure medication count is present. 4-Monitoring of corrective action to ensure the practice will not recur; DON/designee will complete a monthly summary audit to be presented to the monthly QA committee with the Administrator related to documentatin for medications not administered and the medication count at time of discharge. Monthly summary will agian be presented to the Quarterly QA committee with the Administrator and Medical Director. 5-Date systematic changes will be completed and</p>				

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	<p>by mouth.</p> <p>In review of the MAR (Medication Administration Record) for 4-19-14 until discharge on 4-22-14, it indicated the Combivent 18-mcg-103 mg was not administered. Each identified dosage was indicated to have encircled staff initials. There was no indication listed on the back of the MAR or in the nursing progress notes as to why the medication was not administered. Review of the "Packing Slip" from the contracted pharmacy service indicated this medication was not received on the deliveries of late 4-20-14 or early 4-22-14. This medication was not identified to be available in the facility's emergency drug kit (EDK).</p> <p>The MAR for 4-19-14 until discharge on 4-22-14, indicated the Premarin 0.625 mg doses due on 4-20-14 and 4-21-14 had encircled staff initials and the dosage for 4-22-14 was blank. There was no indication listed on the back of the MAR or in the nursing progress notes as to why the medication was not administered. Review of the "Packing Slip" from the contracted pharmacy service indicated 30 tablets of this medication were received on the delivery of early 4-22-14. This medication was not identified to be available in the facility's EDK.</p>		<p>who will be responsible; DON/designee will be responsible for on going compliance. The date of compliance 8/30/2014.</p>				

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	<p>The MAR for 4-19-14 until discharge on 4-22-14, indicated each dosage of Neurontin 300 mg had encircled staff initials. There was no indication listed on the back of the MAR or in the nursing progress notes as to why the medication was not administered for the 4-20-14 doses at 9:00 a.m. and 9:00 p.m. or the 4-21-14 9:00 p.m. doses. This medication was identified to be available from the facility's EDK. Review of the "Packing Slip" from the contracted pharmacy service indicated 60 tablets of this medication were received late evening on 4-20-14.</p> <p>The MAR for 4-19-14 until discharge on 4-22-14, indicated each dosage of the Xarelto 10 mg was left blank. There was no indication listed on the back of the MAR or in the nursing progress notes as to why the medication was not administered. Review of the "Packing Slip" from the contracted pharmacy service indicated 21 tablets were received late evening on 4-20-14. This medication was not identified to be available in the facility's EDK.</p> <p>In an interview with the Director of Nursing on 8-6-14 at 10:17 a.m., she indicated she would expect any medications that were not administered</p>			

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	<p>and had the staff's initials circled on the MAR should have a reason to be documented on the back of the MAR.</p> <p>On 8-6-14 at 1:10 p.m., the Administrator provided a copy of a policy entitled, "Drug Administration-General Guidelines." This policy was indicated to be the current policy and had a revision date listed as 6-19-12. This policy indicated, "Medications are administered as prescribed, in accordance with good nursing principles and practices...If a dose of regularly scheduled medication is withheld [sic], refused, or given at other than the scheduled time (e.g., resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation. If two consecutive doses of a medication are withheld [sic] or refused, the physician is notified..."</p> <p>On 8-6-14 at 1:10 p.m., the Administrator provided a copy of a policy entitled, "Procedure For Using Emergency Dispensing Kits." This policy was indicated to be the current policy and had a revision date listed as 1-27-14. This policy indicated, "An emergency supply</p>			

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	<p>of medications typically used for starter doses is maintained in the facility in limited quantities by the provider pharmacy in a portable, sealed container...The contents of the emergency dispensing kits are listed on the outside of the box. Lists will also be posted at each nursing station...Licensed nurses may utilize the emergency dispensing kits medications only after receiving an order; either written or oral, from the physician for the resident..."</p> <p>B. Resident #A's clinical record was reviewed on 8-4-14 at 2:25 p.m. Her diagnoses included, but were not limited to, C-2 to T-2 (neck and upper back area) fusion with laminectomy, cervical spondylosis, rheumatoid arthritis, anxiety, altered mental status, fall on 4-13-14 resulting in right femur fracture with surgical repair, acute and chronic pain, severe vitamin D deficiency and COPD (chronic obstructive pulmonary disease). The clinical record indicated she was originally admitted to the facility on 4-12-14 and was there for less than 24 hours and then returned to the facility on 4-19-14. She was discharged from the facility on 4-22-14.</p> <p>At the time of Resident #A's discharge, her listing of physician-ordered medications included, but was not limited</p>			

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	<p>to, the following medications:</p> <ul style="list-style-type: none"> <li>-Combivent (a bronchodilator) 18 mcg (micrograms)-103 mg (milligrams) 2 puffs four times daily by mouth via meter-dosed inhaler.</li> <li>-Premarin (estrogen) 0.625 mg daily by mouth.</li> <li>-Neurontin (an anticonvulsant that can used for neuralgia or chronic pain) 300 mg twice daily by mouth.</li> <li>-Xarelto (an anticoagulant) 10 mg daily by mouth.</li> <li>-Norvasc 5 mg daily by mouth.</li> <li>-aspirin 81 mg daily by mouth.</li> <li>-Senna Plus one tablet daily by mouth.</li> <li>-Ergocalciferol 50,000 units daily on Wednesday and Saturday by mouth for 8 weeks.</li> <li>-Fentanyl Patch 12 mcg/hour, applied topically, to be changed every 72 hours.</li> <li>-Zyprexa 2.5 mg every evening by mouth.</li> <li>-Trazadone 25 mg every evening at 6:00 p.m. by mouth.</li> <li>-oxycodone/apap 10/325 mg, 2 tablets, every 6 hours as needed for pain.</li> </ul> <p>In review of the discharge information located in Resident #A's clinical record, there was no indication of which medications or the number of each medication that was provided to the resident upon discharge, except for the oxycodone/apap 10/325 mg. The discharge medication list indicated a</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>14-day prescription was provided for each medication listed. Review of the narcotic log indicated 16 tablets of oxycodone/apap 10/325 mg was sent home Resident #A.</p> <p>In an interview with the Director of Nursing on 8-6-14 at 1:45 p.m., she indicated the facility currently does not identify the number of non-narcotic medications sent home with residents. She indicated if a medication would be sent back to the contracted pharmacy, there would be a credit form in the resident's clinical record or if a medication is destroyed, that information would also be included in the clinical record. She indicated if a medication is provided in a "bubble pack," and has had medication used from the package, it is normally sent home with the resident as the contracted pharmacy normally does not accept an open bubble pack.</p> <p>In an interview with the MDS (Minimum Data Set assessment) Coordinator on 8-6-14 at 1:45 p.m., she indicated the form letter that lists the resident's current medications upon discharge, states the facility will provide a 14-day prescription for medications is incorrect. She indicated the facility normally only provides a 3-day supply of medications to the discharging resident.</p>			

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F000514 SS=D	<p>In an interview with the Administrator on 8-6-14 at 1:45 p.m., she indicated one of the previous discharge forms used by the facility had a place on the form to list the name and number of each medication sent home with the resident.</p> <p>This Federal tag relates to Complaint IN00153582.</p> <p>3.1-25(b)(3) 3.1-25(b)(9) 3.1-25(s)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>A. Based on record review and interview, the facility failed to ensure accuracy of documentation which included medications that were not administered had reasons cited regarding</p>	F000514	F514 It is the intent of this facility to ensure accuracy of documentation which includes medications that are not administered have reasons cited regarding why they were not	08/30/2014			

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	<p>why the medications were not administered for 1 of 3 residents in a sample of 3 reviewed for medication administration. (Resident #A)</p> <p>B. Based on record review and interview, the facility failed to ensure accurate documentation of medication disposition upon discharge from the facility for 1 of 1 residents reviewed for medication disposition in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>A. Resident #A's clinical record was reviewed on 8-4-14 at 2:25 p.m. Her diagnoses included, but were not limited to, C-2 to T-2 (neck and upper back area) fusion with laminectomy, cervical spondylosis, rheumatoid arthritis, anxiety, altered mental status, fall on 4-13-14 resulting in right femur fracture with surgical repair, acute and chronic pain, severe vitamin D deficiency and COPD (chronic obstructive pulmonary disease). The clinical record indicated she was originally admitted to the facility on 4-12-14 and was there for less than 24 hours and then returned to the facility on 4-19-14.</p> <p>In review of the readmission physician orders, dated 4-19-14, it indicated she was to receive the following medications:</p>		<p>administered. It is the intent of this facility to ensure accurate documentation of medication disposition upon discharge from the facility. 1-corrective action for affected resident; Resident #A is no longer in the facility. 2-Other residents with potential to be affected; A-audit completed for all residents current MAR, documentation made as needed by the appropriate staff. B-use of pharmacy medication print out will no longer be utilized independently but will be attached to a discharge form completed by the licensed nurse which includes the medication count. 3-Measure to prevent reoccurrence; A-1-Inservice completed for licensed nurses re: medication administration procedure. A-2-DON/designee to review the MAR and clinical record 3 times a week for 2 months then 2 times a week for 2 months then weekly for 2 months to ensure documentation is completed for medications not administered. B-inservice completed for licensed nurses re; Post discharge to home instructions. B-1-DON/designee to review the post discharge to home instructions 3 times a week for 2 months then 2 times a week for 2 months the weekly for 2 months to ensure medication count is present. 4-Monitoring of corrective action to ensure the practice will not recur; DON/designee will complete a</p>	

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	<p>-Combivent (a bronchodilator) 18 mcg (micrograms)-103 mg (milligrams) 2 puffs four times daily by mouth via meter-dosed inhaler.</p> <p>-Premarin (estrogen) 0.625 mg daily by mouth.</p> <p>-Neurontin (an anticonvulsant that can be used for neuralgia or chronic pain) 300 mg twice daily by mouth.</p> <p>-Xarelto (an anticoagulant) 10 mg daily by mouth.</p> <p>In review of the MAR (Medication Administration Record) for 4-19-14 until discharge on 4-22-14, it indicated the Combivent 18-mcg-103 mg was not administered. Each identified dosage was indicated to have encircled staff initials. There was no indication listed on the back of the MAR or in the nursing progress notes as to why the medication was not administered. Review of the "Packing Slip" from the contracted pharmacy service indicated this medication was not received on the deliveries of late 4-20-14 or early 4-22-14. This medication was not identified to be available in the facility's emergency drug kit (EDK).</p> <p>The MAR for 4-19-14 until discharge on 4-22-14, indicated the Premarin 0.625 mg doses due on 4-20-14 and 4-21-14 had encircled staff initials and the dosage</p>		<p>monthly summary audit to be presented to the monthly QA committee with the Administrator related to documentaiton for medications not administered and the medication count at time of discharge. Monthly summary will again be presented to the Quarterly QA committee with the Administrator and Medical Director. 5-Date systematic changes will be completed and who will be responsible; DON/designee will be responsible for on-going compliance. Date of compliance 8/30/2014.</p>		

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	<p>for 4-22-14 was blank. There was no indication listed on the back of the MAR or in the nursing progress notes as to why the medication was not administered. Review of the "Packing Slip" from the contracted pharmacy service indicated 30 tablets of this medication were received on the delivery of early 4-22-14. This medication was not identified to be available in the facility's EDK.</p> <p>The MAR for 4-19-14 until discharge on 4-22-14, indicated each dosage of Neurontin 300 mg had encircled staff initials. There was no indication listed on the back of the MAR or in the nursing progress notes as to why the medication was not administered for the 4-20-14 doses at 9:00 a.m. and 9:00 p.m. or the 4-21-14 9:00 p.m. doses. This medication was identified to be available from the facility's EDK. Review of the "Packing Slip" from the contracted pharmacy service indicated 60 tablets of this medication were received late evening on 4-20-14.</p> <p>The MAR for 4-19-14 until discharge on 4-22-14, indicated each dosage of the Xarelto 10 mg was left blank. There was no indication listed on the back of the MAR or in the nursing progress notes as to why the medication was not administered. Review of the "Packing</p>				

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	<p>Slip" from the contracted pharmacy service indicated 21 tablets were received late evening on 4-20-14. This medication was not identified to be available in the facility's EDK.</p> <p>In an interview with the Director of Nursing on 8-6-14 at 10:17 a.m., she indicated she would expect any medications that were not administered and had the staff's initials circled on the MAR should have a reason to be documented on the back of the MAR.</p> <p>On 8-6-14 at 1:10 p.m., the Administrator provided a copy of a policy entitled, "Drug Administration-General Guidelines." This policy was indicated to be the current policy and had a revision date listed as 6-19-12. This policy indicated, "Medications are administered as prescribed, in accordance with good nursing principles and practices...If a dose of regularly scheduled medication is withheld [sic], refused, or given at other than the scheduled time (e.g., resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation. If two consecutive doses of a medication are</p>						

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	<p>withheld [sic] or refused, the physician is notified..."</p> <p>On 8-6-14 at 1:10 p.m., the Administrator provided a copy of a policy entitled, "Procedure For Using Emergency Dispensing Kits." This policy was indicated to be the current policy and had a revision date listed as 1-27-14. This policy indicated, "An emergency supply of medications typically used for starter doses is maintained in the facility in limited quantities by the provider pharmacy in a portable, sealed container...The contents of the emergency dispensing kits are listed on the outside of the box. Lists will also be posted at each nursing station...Licensed nurses may utilize the emergency dispensing kits medications only after receiving an order; either written or oral, from the physician for the resident..."</p> <p>B. Resident #A's clinical record was reviewed on 8-4-14 at 2:25 p.m. Her diagnoses included, but were not limited to, C-2 to T-2 (neck and upper back area) fusion with laminectomy, cervical spondylosis, rheumatoid arthritis, anxiety, altered mental status, fall on 4-13-14 resulting in right femur fracture with surgical repair, acute and chronic pain, severe vitamin D deficiency and COPD (chronic obstructive pulmonary</p>			

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	<p>disease). The clinical record indicated she was originally admitted to the facility on 4-12-14 and was there for less than 24 hours and then returned to the facility on 4-19-14. She was discharged from the facility on 4-22-14.</p> <p>At the time of Resident #A's discharge, her listing of physician-ordered medications included, but was not limited to, the following medications:</p> <ul style="list-style-type: none"> <li>-Combivent (a bronchodilator) 18 mcg (micrograms)-103 mg (milligrams) 2 puffs four times daily by mouth via meter-dosed inhaler.</li> <li>-Premarin (estrogen) 0.625 mg daily by mouth.</li> <li>-Neurontin (an anticonvulsant that can used for neuralgia or chronic pain) 300 mg twice daily by mouth.</li> <li>-Xarelto (an anticoagulant) 10 mg daily by mouth.</li> <li>-Norvasc 5 mg daily by mouth.</li> <li>-aspirin 81 mg daily by mouth.</li> <li>-Senna Plus one tablet daily by mouth.</li> <li>-Ergocalciferol 50,000 units daily on Wednesday and Saturday by mouth for 8 weeks.</li> <li>-Fentanyl Patch 12 mcg/hour, applied topically, to be changed every 72 hours.</li> <li>-Zyprexa 2.5 mg every evening by mouth.</li> <li>-Trazadone 25 mg every evening at 6:00 p.m. by mouth.</li> <li>-oxycodone/apap 10/325 mg, 2 tablets,</li> </ul>			

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	<p>every 6 hours as needed for pain.</p> <p>In review of the discharge information located in Resident #A's clinical record, there was no indication of which medications or the number of each medication that was provided to the resident upon discharge, except for the oxycodone/apap 10/325 mg. The discharge medication list indicated a 14-day prescription was provided for each medication listed. Review of the narcotic log indicated 16 tablets of oxycodone/apap 10/325 mg was sent home Resident #A.</p> <p>In an interview with the Director of Nursing on 8-6-14 at 1:45 p.m., she indicated the facility currently does not identify the number of non-narcotic medications sent home with residents. She indicated if a medication would be sent back to the contracted pharmacy, there would be a credit form in the resident's clinical record or if a medication is destroyed, that information would also be included in the clinical record. She indicated if a medication is provided in a "bubble pack," and has had medication used from the package, it is normally sent home with the resident as the contracted pharmacy normally does not accept an open bubble pack.</p>			

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	<p>In an interview with the MDS (Minimum Data Set assessment) Coordinator on 8-6-14 at 1:45 p.m., she indicated the form letter that lists the resident's current medications upon discharge, states the facility will provide a 14-day prescription for medications is incorrect. She indicated the facility normally only provides a 3-day supply of medications to the discharging resident.</p> <p>In an interview with the Administrator on 8-6-14 at 1:45 p.m., she indicated one of the previous discharge forms used by the facility had a place on the form to list the name and number of each medication sent home with the resident.</p> <p>This Federal tag relates to Complaint IN00153582.</p> <p>3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(h)(5)(C)</p>			