STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 12, 13, 14, 18, 19, 2014 Facility number: 000226 Provider number: 155333 AIM number: 100267730 Survey team: Dorothy Watts, RN TC Terri Walters, RN Amy Wininger, RN (8/12/14, 8/13/14, 8/18/14, 8/19/14) Sylvia Scales, RN Census bed type: SNF: 9 SNF/NF: 80 Total : 89 Census payor type: Medicare: 15 Medicaid: 65 Other: 9 Total: 89 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F000000	This plan of correction is to serve as Paoli Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Paoli Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality review completed on August 25, 2014 by Jodi Meyer, RN			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure medications were administered according to the physician's orders, in that, insulin and respiratory treatments were not administered according to the physician orders for 1 of 5 residents who met the criteria for review of unnecessary medications (Resident #66) Findings include: The clinical record of Resident #66 was reviewed on 08/18/14 at 3:00 P.M. The record indicated the diagnoses of Resident #66 included, but were not limited to, diabetes, and exacerbation of COPD (Chronic Obstructive Pulmonary Disease), and Pneumonia (a pulmonary infection). The Admission MDS (Minimum Data Set Assessment) dated 05/09/14 indicated Resident #66 experienced moderate cognitive impairment, no episodes of care rejection, and received insulin daily.	F000282	F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Resident # 66 is receiving medications according to the physician's order. All residents receiving insulin and/or respiratory treatments have been identified and will be reviewed for receiving their medications according to the physician's order. Any concerns will be addressed. The systemic change includes: · Licensed nurses and QMAs will complete a clinical competency regarding administration of insulin and/or respiratory treatments per physician's order. This competency will be completed upon hire and annually thereafter. · Licensed nurses and QMAs will complete a check of the MAR at change of shift for any holes in the	09/18/2014

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	The most recent Quarterly MDS dated 06/13/14 indicated Resident #66 experienced minimal cognitive impairment, no episodes of care rejection, and received insulin daily. The most recent Physician's Order Recap dated 07/16/14 included, but was not limited to, orders for: "...Lantus (a slow-acting insulin)...inject 45 units subcutaneously every morning and evening... ...Novolog inject (a fast-acting insulin)...per sliding scale before meals 151-200-10 units; 251-300=18 units; 201-250=14 units; 301-350=20 units; >(greater than) 351=22 units and call MD:...7:30 A.M....11:30 A.M.....4:30 A.M... ...Novolog inject...per sliding scale: at bedtime: 71-200= 0 units 201-250=2 units; 251-300=4 units; 301-350=5 units; 351-400=6 units; >401=7 units and call MD (physician)...Check blood sugar before		documentation. This will be completed between the on-coming nurse/QMA with the off-going nurse/QMA to review any concerns with documentation of medication administration. Licensed nurses and QMAs will be offered education regarding administering insulin and/or respiratory treatment per physician's order and documentation requirements for the same. This education will include the check off of the MAR between shifts. The education will be provided for all newly hired nursing staff. The DON or designee, will complete a QA tool to audit documentation of insulin administration and respiratory treatments daily (including weekends) for 30 days, then weekly for 60 days, then every other week for a total 12 months of monitoring The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 09/18/14	

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	meals and at bedtime call MD<(less than) 60 or > 400... ...Albuterol neb (nebulizer) ...one vial per nebulizer every 8 hrs (hours) while awake (0600, 1400, 2200)..." A Physician's Telephone Order dated 07/16/14 indicated a new order was received for, "...increase Lantus by 4 units from current dose..." A Care Plan dated 05/05/2014 for "...Potential for hypo/hyperglycemia and diabetic complication related to diabetes mellitus..." included, but was not limited to, interventions of "...administer ...any insulin coverage per MD (physician) order..." A Care Plan dated 05/05/14 for "...Potential for respiratory distress related to COPD..." included, but was not limited to, interventions of "...administer medication per MD order..." The August 2014 MAR lacked any documentation Resident #66 received 49 units of Lantus insulin on the following dates: 08/03/14 at 4:30 P.M. 08/06/14 at 7:30 A.M. 08/09/14 at 07:30 A.M.			

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	The August 2014 MAR lacked any documentation Resident #66 received Novolog insulin per sliding scale on the following dates: 08/04/14 at 11:30 A.M. for Accucheck result of 244 mg(milligram)/dl (deciliter). (14 units of Novolog should have been administered) 08/05/14 at 7:30 A.M. for Accucheck result of 179 mg/dl (10 units of Novolog should have been administered) 08/07/14 at 7:30 A.M. for Accucheck result of 222 mg/dl (14 units of Novolog should have been administered) 08/08/14 at 7:30 A.M. Documentation was lacking an Accucheck result. 08/09/14 at 7:30 A.M. Documentation was lacking an Accucheck result. 08/10/14 at 4:30 P.M. for Accucheck result of 176 mg/dl. (10 units of Novolog should have been administered) 08/12/14 at 7:30 A.M. for Accucheck result of 267 mg/dl (18 units of Novolog should have been administered) 08/12/14 at 11:30 A.M. for Accucheck result of 231 mg/dl (14 units of Novolog			

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	should have been administered) 08/16/14 at 8:30 P.M. Documentation was lacking an Accucheck result. The August 2014 Respiratory Therapy Worksheet lacked any documentation Resident #66 was asleep or awake and/or received an Albuterol breathing treatment on the following dates: 08/04/14 at 2:00 P.M. 08/06/14 at 2:00 P.M. 08/06/14 at 10:0 P.M. 08/07/14 at 2:00 P.M. 08/10/14 at 2:00 P.M. 08/11/14 at 10:00 P.M. 08/12/14 at 6:00 A.M. 08/13/14 at 2:00 P.M. 08/14/14 at 2:00 P.M. 08/14/14 at 10:00 P.M. 08/17/14 at 2:00 P.M. The August 2014 MAR lacked any documentation Resident #66 was asleep or awake and/or received an Albuterol respiratory treatment on the following dates: 08/04/14 at 2:00 P.M. 08/06/14 at 2:00 P.M. 08/06/14 at 10:0 P.M. 08/07/14 at 2:00 P.M. 08/10/14 at 2:00 P.M.			

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	08/11/14 at 10:00 P.M. 08/12/14 at 6:00 A.M. 08/13/14 at 2:00 P.M. 08/14/14 at 2:00 P.M. 08/14/14 at 10:00 P.M. 08/17/14 at 2:00 P.M. During an interview on 08/19/14 at 2:30 P.M., Resident #66 was observed sitting on the patio and indicated, at that time, she took insulin routinely, but could not remember exactly what she was supposed to take and then indicated she only took breathing treatments in the morning and evening, not in the afternoon. During an interview on 08/19/14 at 3:00 P.M., The DON (Director of Nursing) indicated no documentation could be provided to indicate Resident #66 had received Lantus, Novolog, and/or Albuterol treatments as ordered. The DON further indicated, at that time, nursing staff was expected to administer medications as ordered by the physician. The DON then indicated documentation was lacking to indicate if Resident #66 was awake or asleep at the time of the scheduled breathing treatments that were not documented. 3.1-35(g)(2)			
F000323	483.25(h)			

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SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision and/or effective interventions were provided, in that, a resident was left unattended in the shower room and experienced a fall (Resident #55) and/or safety equipment did not activate and the resident experienced 2 falls. (Resident #17). This deficient practice resulted in Resident #17 experiencing fractures to the left shoulder, right first metacarpal, and right patella. Findings include: 1. During an observation on 8/18/14 Resident #17 was observed sitting in her recliner with her walker in front of her. The Clinical Record of Resident #17 was reviewed on 8/18/14 at 3:38 P.M. The record indicated Resident #17 was admitted on 10/10/2009 with diagnoses including, but not limited to, difficulty walking, dementia with behavioral disturbances, and weak muscles.	F000323	Paoli Health and Living Community respectfully request an informal dispute resolution face to face regarding F323. The facility feels there are some discrepancies in the findings of the 2567. The facility feels that the appropriate action was taken in that interventions were adequate and appropriate as well as supervision was provided. We are requesting a removal and/or decrease in the scope and severity for F323.F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Resident # 55 and #17 are receiving adequate supervision and/or effective interventions to prevent accidents. All residents at risk for falls have been identified and will be reviewed for adequate supervision and/or effective interventions to prevent accidents. This review includes an audit of safety equipment for function. Any concerns will be addressed. The systemic change includes: · C NA assignment sheets identify the current interventions for a resident at risk for falls and the amount of supervision required by the resident. · Charge nurses will complete rounds with a C.N.A. on	09/18/2014

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	Fall 1. A Progress Noted dated 1/3/14 at 1:00 A.M. read as follows: "Called to res (resident) room 301, found res lying supine on floor. Res had "L" shaped lac (laceration) to upper lip, with bleeding controlled. Nose sl (slight) swollen with blood at bil (bilateral) nares. Bil patellae with hematomas. Post right hand ecchymotic. C/o (complains of) L (left) upper arm/shoulder pain...States 'I thought I could make it to the bathroom'...transfer res to ER (emergency room) for evaluation." A Progress Note dated 1/3/14 5:20 A.M. read as follows: "Report received from (name of hospital) ER that res has been sent to (another hospital in a different town) for admission there, with with dx: (diagnosis) Fx (fracture) L (Left) humerus, Fx R (Right) hand/thumb, and Fx R Patella." The Admission MDS (Minimum Data Set Assessment) dated 10/22/13 indicated Resident #17 had moderate cognitive impairment and required extensive assistance of two people with transfers and the assistance of 1 person when ambulating. Resident #17 was only able to stabilize with assistance for balance, transfers and walking. The Discharge MDS (Minimum Data Set		her assigned hall to review for effectiveness of current interventions and supervision of the residents at risk for falls. · All residents will be reviewed on admission, quarterly, and upon change of condition for a change in fall risk and effectiveness of the current interventions and if a change in supervision is needed. · An internal QA document has been developed for staff to complete a thorough review of the effectiveness of a resident's interventions and functioning at the time of a fall. Charge nurses are required to call a nursing administration team member at the time of the fall to discuss effectiveness of current interventions and plan for the new intervention. Nursing staff will be offered education on the updated C.N.A. assignment sheets, completion of rounds, the internal QA document for investigation of falls and the review of residents upon admission, quarterly, and with any change in condition. This education will also be completed upon hire of new nursing staff, annually and as needed. The DON or designee will complete a QA tool monitoring 5 random residents on random shifts, 7 days a week, for provision of supervision and effective fall interventions per the plan of care to review for appropriateness and effectiveness. This review will continue 7 days a week for 30	

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	Assessment) dated 1/3/14 indicated Resident #17 had moderate cognitive impairment and required the assistance of 1 person with transfers and ambulating. Resident #17 was only able to stabilize with assistance for balance, transfers and walking. A Care Plan for falls with a start date of 11/2/13 read as follows: "...Up with the assist of one with walker for transfers and ambulation...Alarm to bed and chair. Check placement and function every shift." An Admission Fall Risk Assessment dated 12/28/13 10:10 P.M. indicated Resident #17 had experienced "One or Two Falls" in the last 3 months and was at risk for experiencing a fall. The (hospital name) Emergency Room discharge deposition dictated 1/3/14 for Resident #17 read as follows: "ASSESSMENT 1. Left Shoulder fracture dislocation. 2. Right first metacarpal fracture. 3. Right patella fracture...." Fall 2. A Progress Noted dated 6/14/14 at 1:10 A.M., read as follows: "Walking down hall, Pt (patient) roommate hollered out and found name (Resident #17) in floor sitting upright on bottom in		days, then weekly for 60 days, then every other week for 30 days, then monthly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 09/18/14	

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	floor in front of sink in the bathroom....when asked why she didn't sound alarm or wait for someone she stated "I couldn't and had to go to bathroom" A Fall Event Report dated 6/22/14 provided by the DON indicated the following: Resident #17 was toileting at the time of the fall. The fall risk score indicated Resident #17 was at risk for falling. The interventions which were in place at the time of the fall were non-skid footwear, chair alarm and bed alarm. The new immediate interventions initiated were bed alarm and other-type of alarm changed. A Care Plan for Falls Dated 6/16/14 was provided by the DON and read as follows: "Approach Date 6/16/14 - DC on: 7/1/14...RD (resident) to have bed chair alarm that can't be turned off R/T Rd (resident) history of turning alarms off." During an interview on 8/19/14 at 10:00 A.M., the Director of Nursing (DON) indicated Resident #17 had a bed alarm and a chair alarm in place at the time of the falls on 1/3/14 and 6/14/14, but the clinical record lacked documention the alarms were sounding/functioning before Resident #17 fell. The DON further			

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	indicated Resident #17 had a history of removing her alarms. The Policy titled Fall Management Program was provided by the Regional Nurse Consultant and included, but was not limited to, "...The goal of the interdisciplinary team is to identify residents with a history of and potential for falls and develop an effective individualized fall management plan..." 2. On 8/14/14 at 8:25 A.M., Resident #55 was observed in bed with 1/2 side rails in place and call light in reach. Resident # 55's clinical record was reviewed on 8/14/14 at 11:13 A.M. Resident #55 had been admitted to the facility on 2/11/14. Her diagnoses included but were not limited to, atrophy muscular disuse, difficulty in walking, dementia, vascular with depressed mood, benign neoplasm of brain, suicidal ideation, anxiety state, symptom hallucinations, and nonorganic psychosis. Her clinical record indicated she had been admitted to a hospital behavioral unit on 7/2/14 related to depression and the voicing of suicide ideation. She had returned to the facility on 7/15/14. On return to the facility on 7/15/14 she had been placed on 15 minute checks for 72 hours to monitor behavior. Fifteen			

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	minute checks were discontinued after a visit from the psychologist on 7/17/14. Her Minimum Data Set Assessment (MDS) dated 6/24/14 (before fall) indicated, a cognitive summary score of 11 (moderate cognitive impairment score of 8-12). The MDS indicated, extensive assistance of 2 or more staff were needed for bed mobility, and the extensive assistance of 1 staff was needed for transfers. The MDS also indicated limited assistance of 1 staff needed for walking in room and total dependence for bathing with 2 staff to physically assist. The MDS dated 7/21/14 (after fall) indicated a cognitive score of 10. The assessment indicated extensive assistance of 2 or more staff needed for bed mobility, transfers, and walking in room. The MDS indicated total dependence for bathing with 2 or more staff to physically assist. A care plan with an initiation date of 7/14/14, indicated a problem of the resident being at risk for falls related to weakness. Interventions initiated on 7/15/14 indicated, "Assist with ADLs (activities of daily living) as needed, Cue/remind resident to use call lights to seek assistance as needed, Keep call light in reach at all times, Keep personal items and frequently used items within			

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	reach, and transfer independently, ambulation asst (assist) x 1 w/rw (with rolling walker)." After the fall of 7/16/14, an intervention was initiated on 7/17/14, which indicated, "Use emergency call light for supplies needed in shower room." A progress note dated 7/16/14 at 4:25 A.M., indicated, "Staff called to shower room. Resident sitting on floor in shower room. No c/o (complaint) pain/discomfort. No injuries noted at this time. V/S (vital signs) within normal limits. Neuro (neurological) checks initiated..." A Fall Event record completed on 7/16/14 at 4:11 P.M., indicated an unwitnessed fall had occurred in the shower room. The documentation indicated there had been no injury. The record indicated Resident #55 had a high fall risk score of 11(a score of 10 or higher being high risk). Interventions listed in place at time of the fall were non-skid footwear. New immediate interventions that were initiated after the fall were: offer resident food and drink, toileting, and "...Assistive devices and personal care items placed within resident's reach." On 8/18/14 at 9:01 A.M., the Director of			

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	Nursing (DON) was interviewed regarding the 7/16/14 at 4:25 A.M., unsupervised fall in the shower room. The DON indicated staff had completed the resident's shower and the resident's socks were wet. The DON indicated the CNA had stepped out of the shower room to get dry socks . The DON indicated when staff had returned Resident #55 had fallen. The DON indicated at that time, the CNA should not have left the resident unsupervised in the shower room. On 8/19/14 at 7:55 A.M., the Director of Therapy was interviewed regarding Resident #55's therapy and mobility status. The Director of Therapy indicated Resident #55 had been on therapy caseload before hospitalization (5/15/14 to 6/25/14) and was picked up after hospitalization (7/15/14 to 8/11/14). He indicated Resident #55 would need assistance for transfer from a shower chair to a wheelchair. On 8/19/14 at 8:15 A.M., MDS Nurse #1 was interviewed and indicated the MDS (6/24/14) before hospitalization, indicated Resident #55 needed extensive assistance of 1 staff for transfer. She reviewed the MDS of 7/21/14 and indicated, extensive assistance of 2 or more staff were needed for bed mobility, transfer, and ambulation. The MDS			

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	Nurse #1 also indicated at that time, she was only aware of Resident #55 needing assistance to transfer since she had been a resident at the facility. She indicated at that time Resident #55 should not have been left in the shower unsupervised. She indicated there were no residents currently at the facility who shower independently. On 8/19/14 at 2:40 P.M., a hospital x-ray report of Resident #55 dated 7/6/14, was reviewed. The report indicated "...pt. (patient) fell from bed onto left forearm/swelling on ulnar side..." On 8/19/14 at 2:40 P.M., the Regional Nurse Consultant was made aware that Resident #55 had fallen during hospitalization before readmission to the facility. She indicated at that time she was unaware that Resident #55 had fallen during hospitalization.. A hospital transfer sheet from the behavioral unit of the hospital to the nursing facility (dated 7/14/14) for readmission, included but was not limited to the following information, "...ptn (patient) has difficulty with weight bearing..." "...Needs help with Bathing, Dressing, Ambulation, Up In Chair, Wt. Bearing, Exercises..." 3.1-45(a)(2)			

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F000328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview, and record, the facility failed to ensure care was provided, in that, respiratory treatments were not provided for 1 of 1 residents who met the criteria for review of respiratory care. (Resident #66) Findings include: The clinical record of Resident #66 was reviewed on 08/18/14 at 3:00 P.M. The record indicated the diagnoses of Resident #66 included, but was not limited to, exacerbation of COPD (Chronic Obstructive Pulmonary Disease), pneumonia (a pulmonary infection). The Admission MDS (Minimum Data Set Assessment) dated 05/09/14 indicated Resident #66 experienced moderate cognitive impairment, no episodes of care	F000328	F328 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS Resident # 66 is receiving respiratory treatments as ordered. All residents with respiratory treatments have been identified and will be reviewed for receiving respiratory treatments as ordered. Any concerns will be addressed. The systemic change includes nursing staff will complete a competency check on delivering respiratory treatments as ordered and documentation of the same. In addition, licensed nurses and QMAs will complete a check of the MAR at change of shift for any holes in the documentation. This will be completed between the on-coming nurse/QMA with the off-going nurse/QMA to review any concerns with documentation of medication	09/18/2014

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	rejection, experienced frequent pain, and received insulin daily. The most recent Quarterly MDS dated 06/13/14 indicated Resident #66 experienced minimal cognitive impairment, no episodes of care rejection, experienced frequent pain, and received insulin daily. The most recent Physician's Order Recap dated 07/16/14 included, but was not limited to, orders for: "...Albuterol neb (nebulizer) ...one vial per nebulizer every 8 hrs (hours) while awake (0600, 1400, 2200)..." The August 2014 Respiratory Therapy Worksheet lacked any documentation Resident #66 was asleep or awake and/or received an Albuterol breathing treatment on the following dates: 08/04/14 at 2:00 P.M. 08/06/14 at 2:00 P.M. 08/06/14 at 10:0 P.M. 08/07/14 at 2:00 P.M. 08/10/14 at 2:00 P.M. 08/11/14 at 10:00 P.M. 08/12/14 at 6:00 A.M. 08/13/14 at 2:00 P.M. 08/14/14 at 2:00 P.M. 08/14/14 at 10:00 P.M. 08/17/14 at 2:00 P.M.		administration. Licensed nurses will be offered education on administering respiratory treatments as ordered and documentation of the same. This education will also be provided upon hire of licensed nurses. The DON or designee will complete a QA audit tool daily to audit documentation of respiratory treatments daily (including weekends) for 30 days, then weekly for 60 days, then every other week for a total 12 months of monitoring The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 09/18/14	

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	The August 2014 MAR lacked any documentation Resident #66 was asleep or awake and/or received an Albuterol respiratory treatment on the following dates: 08/04/14 at 2:00 P.M. 08/06/14 at 2:00 P.M. 08/06/14 at 10:0 P.M. 08/07/14 at 2:00 P.M. 08/10/14 at 2:00 P.M. 08/11/14 at 10:00 P.M. 08/12/14 at 6:00 A.M. 08/13/14 at 2:00 P.M. 08/14/14 at 2:00 P.M. 08/14/14 at 10:00 P.M. 08/17/14 at 2:00 P.M. During an interview on 08/19/14 at 2:30 P.M., Resident #66 was observed sitting on the patio and indicated, at that time, she took insulin routinely, but could not remember exactly what she was supposed to take and then indicated she only took breathing treatments in the morning and evening, not in the afternoon. During an interview on 08/19/14 at 3:00 P.M., The DON (Director of Nursing) indicated no documentation could be provided to indicate Resident #66 had received Albuterol treatments as ordered. The DON further indicated, at that time,			

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	nursing staff was expected to administer medications as ordered by the physician. The DON then indicated documentation was lacking to indicate if Resident #66 was awake or asleep at the time of the scheduled breathing treatments. 3.1-47(a)(6)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview, and record, the facility failed to ensure medications were clinically indicated for 2 of 5 residents who met the criteria for	F000329	F329 483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Resident #66 has a pain assessment	09/18/2014

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	reviewed for unnecessary medications. (Resident #66, Resident #4) Findings include: 1. The clinical record of Resident #66 was reviewed on 08/18/14 at 3:00 P.M. The record indicated the diagnoses of Resident #66 included, but were not limited to, chronic pain. The Admission MDS (Minimum Data Set Assessment) dated 05/09/14 indicated Resident #66 experienced moderate cognitive impairment and experienced frequent pain. The most recent Quarterly MDS dated 06/13/14 indicated Resident #66 experienced minimal cognitive impairment and experienced frequent pain. The most recent Physician's Order Recap dated 07/16/14 included, but was not limited to, orders for, "...Oxycod (Oxycodone)/APAP (Acetaminophen) (Percocet) 10-325 mg (milligrams) take 1 (one) tablet by mouth four times daily as needed..." A Care Plan dated 05/06/14 for "...Potential for pain..." included, but was not limited to, interventions of,		completed prior to and after administration of her pain medication and a follow up for effectiveness is completed. Resident #4 is now receiving her Zolpidem routinely per a new physician order. All residents receiving prn pain and/or hypnotic medications over the last 30 days have been identified and will be audited for completion of a pain assessment prior to and after administration of a pain medication as well as a follow up assessment. All residents receiving prn hypnotics have been identified and will be reviewed for documentation of interventions prior to administering the medication and follow up documentation of effectiveness. Any concerns will be addressed. The systemic change includes: · Licensed nurses and QMAs will complete a competency check regarding completing a pain assessment prior to and after administration of prn pain medication and follow up for effectiveness. This competency check will also include documentation of interventions prior to administering hypnotics and following up with documentation of effectiveness.	

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	"...administer medications per MD order, return to assess effectiveness..." A Controlled Drug Record dated 08/08/14 through 08/14/14 indicated Resident #66 received Percocet on the following dates: 08/07/14 at 8:00 P.M. 08/08/14 at (illegible) 08/08/14 at 11:00 A.M. 08/09/14 at 6:00 A.M. 08/10/14 at 1:00 P.M. 08/11/1 4 at 4:00 P.M. 08/13/14 9:30 P.M. 08/14/14 at 4:00 A.M. 08/14/14 at 8:30 P.M. The PRN Pain Assessment Monitoring form dated 08/01/14 through 08/14/14 lacked any documentation a pain assessment was completed before the administration of Percocet on the following dates: 08/07/14 at 8:00 P.M. 08/08/14 at (unknown time) 08/08/14 at 11:00 A.M. 08/09/14 at 6:00 A.M. 08/10/14 at 1:00 P.M. 08/11/14 at 4:00 P.M. 08/13/14 at 9:30 P.M. 08/14/14 at 4:00 A.M. 08/14/14 at 8:30 P.M. The Nursing Progress Notes from		· Licensed nurses and QMAs will complete a check of the MAR at change of shift for any holes in the documentation. This will be completed between the on-coming nurse/QMA with the off-going nurse/QMA to review any concerns with documentation of medication administration. Education will be offered to licensed nurses regarding the proper documentation of a pain assessment prior to and after administration of a prn pain medication as well as follow up documentation for effectiveness. In addition, education will be provided for proper documentation of an intervention prior to administration of a prn hypnotic as well as follow up documentation of effectiveness. This education will also be provided to new hired nurses. The DON or designee will complete a QA audit tool monitoring documentation of a pain assessment prior to and after administration of a prn pain medication as well as follow up documentation of effectiveness of the medication. In addition, the QA auditing tool will include monitoring of documentation of an intervention attempted prior to administration of a prn hypnotic agent as well as documentation of the effectiveness. This auditing will be completed daily (including weekends) for 30 days, weekly for 5	

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	08/01/14 through 08/14/14 lacked any documentation the pain of Resident #66 was assessed prior to the administration of Percocet. The PRN (as needed) Pain Assessment Monitoring Form dated 08/01/14 through 08/14/14 indicated Resident #66 received Percocet without follow up assessment on the following dates: 08/01/14 at 1:30 P.M. 08/02/4 at 9:00 P.M. 08/06/14 at 7:30 P.M. 08/10/14 at 9:00 P.M. 08/14/14 at 2:00 P.M. The Nursing Progress Notes from 08/01/14 through 08/14/14 lacked any documentation to indicate Resident #66 was monitored for pain relief after the administration of Percocet. During an interview on 08/19/14 at 2:30 P.M., Resident #66 was observed sitting on the patio and indicated, at that time, the nurses did not always check if her pain was relieved after she received pain medication. During an interview on 08/19/14 at 3:00 P.M., The DON (Director of Nursing) indicated the nursing staff should assess a resident's pain before administering as needed pain medication and should		months and then monthly for an additional 6 months for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 09/18/14	

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	monitor the resident for pain relief after administering as needed pain medication. The Policy and Procedure for Pain Management provided by the Regional Nurse Consultant on 08/19/14 at 3:40 P.M. indicated, "...PRN Pain Medication - When analgesics are administered...nurses must document their assessment...and the effectiveness of the treatment on the PRN Pain Assessment Monitoring Form..." 2. On 8/12/14 at 10:48 A.M., Resident #4 was observed sitting in a recliner in her room. The Clinical Record for Resident #4 was reviewed on 8/14/14 at 10:01 A.M., diagnoses include, but were not limited to, hypertension, dementia and anxiety. The care plans included, but were not limited to, use of antipsychotic and hypnotic medication. The signed physician 's order dated July 2014 included, but was not limited to, Zolpidem (a hypnotic drug) one tab at bedtime as needed (PRN) for insomnia starting on February 2nd, 2014 The Controlled Drug Record for the administration of Zolpidem was reviewed on 8/18/14 at 12:36 P.M., it indicated			

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	Resident #4 had received the medication on the following dates and times: 8/1/14 at 1900 (7:00 P.M.) 8/2/14 at 20:30 (8:30 P.M.) 8/3/14 at 19:00 (7:00 P.M.) 8/4/14 at 20:30 (8:30 P.M.) 8/5/14 at 20:00 (8:00 P.M.) 8/6/14 at 20:30 (8:30 P.M.) 8/7/14 at 19:00 (7:00 P.M.) 8/8/14 at 19:00 (7:00 P.M.) 8/9/14 at 19:00 (7:00 P.M.) 8/10/14 at 19:00(7:00 P.M.) 8/11/14 at 20:20 (8:20 P.M.) 8/12/14 at 20:30 (8:30 P.M.) 8/13/14 at 20:00 (8:00 P.M.) 8/14/14 at 19:00 (7:00 P.M.) 8/15/14 at 19:00 (7:00 P.M.) 8/16/14 at 19:00 (7:00 P.M.) 8/17/14 at 19:00 (7:00 P.M.) The "PRN MEDICATION ADMINISTRATION MONITORING FORM" for Resident #4 was reviewed on 8/18/14 at 12:36 P.M. It lacked any documentation of interventions and effectiveness of Zolpidem on following dates and times: 8/1/14 at 1900 (7:00 P.M.) 8/2/14 at 20:30 (8:30 P.M.) 8/3/14 at 19:00 (7:00 P.M.) 8/4/14 at 20:30 (8:30 P.M.) 8/6/14 at 20:30 (8:30 P.M.) 8/7/14 at 19:00 (7:00 P.M.) 8/8/14 at 19:00 (7:00 P.M.)			

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	8/9/14 at 19:00 (7:00 P.M.) 8/10/14 at 19:00(7:00 P.M.) 8/11/14 at 20:20 (8:20 P.M.) 8/12/14 at 20:30 (8:30 P.M.) 8/13/14 at 20:00 (8:00 P.M.) 8/14/14 at 19:00 (7:00 P.M.) 8/15/14 at 19:00 (7:00 P.M.) 8/17/14 at 19:00 (7:00 P.M.) The nursing progress notes for Resident #4 were reviewed. Documentation was lacking in regards to attempted interventions and or effectiveness of any PRN medication administered to Resident #4. During an interview with LPN #4 on 8/18/14 at 10:44 A.M., she indicated that before administration of a PRN medication appropriate non-pharmacological interventions should be documented on the facility " PRN MEDICATION ADMINISTRATION FORM ". She further indicated that after the administration of a PRN medication the nurse should go back and assess for effectiveness of the medication and document on the form. On 8/19/14 at 9:20 A.M., during an interview, the Director of Nursing was			

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	interviewed, she indicated it was the facility policy for nurses to offer and document non-pharmacological interventions prior to the administration of any PRN medication. She further indicated that effectiveness of the medication should be assessed after administration. The facility was unable to provide any further documentation to show that non-pharmacological interventions were attempted and/or effectiveness of the hypnotic medication was being monitored for Resident #4. 3.1-48(a)(3) 3.1-48(a)(4)			
F000332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate greater than 5% in that the facility had 3 medication errors out of 26 opportunities for error, resulting in an 11.5 % error rate. This affected 1 of 11 residents observed during the medication pass (Resident #92), and 1 of 8 nurses observed to pass medications. (LPN #8)	F000332	F332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE Resident #92 is receiving accuchecks and insulin as ordered by the physician. LPN #8 has received one on one education regarding the policy on administration of insulin and following physician orders	09/18/2014

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	Findings include: During observation of the medication pass on 08/18/14 at 8:58 A.M., LPN #8 prepared Resident #92's medication, obtained the glucometer (equipment used by diabetics to measure the amount of sugar in the blood) and proceeded into the resident's room. LPN #8 administered the medication and obtained a blood glucose reading of 217. LPN #8 checked the Medication Administration Record (MAR) and determined that Resident #92 was prescribed 10 units of Novolog per sliding scale for a blood sugar range of 217 and 10 units of Lantus insulin (long acting insulin used to control blood sugar). LPN #8 looked through the medication cart and could not locate Resident #92's Lantus insulin injectable pen. At that time, LPN #8 indicated she would obtain a Lantus insulin pen from the EDK (Emergency Drug Kit). Upon checking the EDK and back up supplies for a new Lantus insulin pen, LPN #8 indicated there was no Lantus insulin in the facility and that she needed to telephone the pharmacy to order a Lantus insulin pen STAT (immediately). During an interview on 08/18/14 at 9:10 A.M., LPN #8 indicated a blood sugar		regarding insulin and accuchecks. All residents with current physician orders for accuchecks and insulin have been identified and will be reviewed for administration of the accucheck and/or insulin per facility policy and physician order. Any concerns will be addressed. The systemic change includes: · Nurses will complete a competency evaluation regarding administration of accuchecks and insulin per facility policy and physician order. This competency check will also be completed with newly hired nurses · Nurses will request assistance from nursing administration or another nurse if an event occurs that would prevent him/her to perform the accuchecks and insulins per orders and time frames Education will be provided to licensed nurses regarding administration of accuchecks and insulins per facility policy and physician order and within the timeframes per policy. This education will include the need to request assistance from nursing administration or another nurse if accucheck or insulin delivery will be delayed. The Unit Manager or designee will	

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	reading, Novolog insulin administration per sliding scale and the Lantus insulin administration were scheduled for 7:30 A.M., and that these procedures should have been completed before Resident #92 ate breakfast. LPN #8 further indicated she had been busy with another resident this morning and was unable to complete these tasks on time. LPN #8 called the physician on 8/18/14 at 10:30 A.M. and obtained an order to hold the Lantus insulin dose for 8/18/14 and resume Lantus insulin on 8/19/14. Resident #92 was administered 10 units of Novolog insulin at 10:45 A.M. During an interview with Resident #92 on 8/18/14 at 11:05 A.M., Resident #92 said, "I waited for awhile this morning and did not eat, but the nurse was busy so I went ahead and ate my breakfast. I ate biscuits,gravy and eggs. I know it will make my numbers go up. My blood sugar should be checked in the morning before I go to breakfast and my insulin should be given before breakfast." The clinical record of Resident #92 was reviewed on 08/18/14 at 9:30 A.M. The record indicated the diagnoses of Resident #92 included, but were not limited to, insulin dependent diabetes mellitus.		complete a QA audit tool to monitor 2 random nurses on 2 different shifts for accucheck and insulin administration for timeliness and per MD orders, on 2 residents per nurse daily for 30 days, then weekly for 30 days, then every other week for 4 months, then monthly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 09/18/14	

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	The most recent Physician Order Recap dated 08/2/14 included, but was not limited to, orders for, "...Accuchecks Twice Daily...07:30 (7:30 A.M.) ... Lantus Inj Solostar inject 10 units ...every morning...0730...Novolog inj FLEXPEN Inject subcutaneously per sliding scale: every morning and evening...201-225=10 units..." The Policy and Procedure "Diabetes - Clinical Protocol" provided by the DON (Director of Nursing) on 08/19/14 at 3:08 P.M. indicated, "...2. the Physician will order appropriate lab test ...(periodic finger sticks)...and adjust treatments based on the results...a...(3) For the resident receiving insulin...monitor blood glucose levels twice a day if on insulin... (for example, before breakfast and lunch and as necessary)...monitor 3 to 4 times a day if on...sliding scale..." During an interview on 8/19/14 at 3:37 P.M., LPN #15 indicated Accuchecks (blood sugar checks) and insulin administration should be completed before meals. During an interview on 8/19/14 at 3:41 P.M., the Director of Nursing (DON) indicated glucometer checks (blood sugar levels) should be done before meals because the sliding scale for Novolog is			

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	based on the blood sugar level. The failure to check Resident #92's blood sugar levels before eating, the failure to administer medications (which included Lantus and Novolog) as ordered by the physician and the failure to perform an Accucheck within the allowed time frame, resulted in 3 (3) medication errors. 3.1-25(b)(9) 3.1-48(c)(1)			
F000333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure insulins were administered correctly, in that, Humalog (a fast acting insulin) and Lantus insulin were not administered according to the manufacturer's instruction and/or the physician's order. This affected 1 of 2 residents observed for insulin administration during the medication administration (Resident #17), and 1 of 8 nurses observed passing medications. (LPN #8) Findings include:	F000333	F333 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS Resident #17 is receiving insulin according to manufacturer's instruction and/or the physician order. LPN #8 received one on one education regarding administering insulin according to manufacturer's instruction /or per the physician order. All residents receiving insulin have been identified and will be reviewed for administration of insulin according to manufacturer's instruction and/or per the physician order over the last 30 days. Any	09/18/2014

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	During observation of the medication pass on 08/18/14 at 8:58 A.M., LPN #8 prepared Resident #92's medication, obtained the glucometer (equipment used by diabetics to measure the amount of sugar in the blood) and proceeded into the resident's room. LPN #8 administered the medication and obtained a blood glucose reading of 217. LPN #8 checked the Medication Administration Record (MAR) and determined that Resident #92 was prescribed 10 units of Novolog per sliding scale for a blood sugar range of 217 and 10 units of Lantus (long acting insulin used to control blood sugar). LPN #8 looked through the medication cart and could not locate Resident #92's Lantus insulin injectable pen. At that time, LPN #8 indicated she would obtain a Lantus insulin pen from the EDK (Emergency Drug Kit). Upon checking the EDK and back up supplies for a new Lantus insulin pen, LPN #8 indicated there was no Lantus insulin in the facility and that she needed to telephone the pharmacy to order a Lantus insulin pen STAT (immediately). During an interview on 08/18/14 at 9:10 A.M., LPN #8 indicated a blood sugar reading, Novolog insulin administration per sliding scale and the Lantus insulin administration were scheduled for 7:30 A.M., and that these procedures should		concerns will be addressed. The systemic change includes licensed nurses will complete a competency evaluation regarding administration of insulin according to manufacturer's instruction and/or per the physician order and accurate documentation of the same. Newly hired nurses will also complete this competency evaluation. Education will be provided to licensed nurses regarding administration of insulin according to manufacturer's instruction and/or per the physician order and accurate documentation of the same. This inservice will also be provided yearly. The Unit Manager or designee will complete a QA audit tool to monitor 2 random nurses on 2 different shifts for insulin administration for timeliness and per MD orders, on 2 residents per nurse daily for 30 days, then weekly for 30 days, then every other week for 4 months, then monthly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is	

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	have been completed before Resident #92 ate breakfast. LPN #8 further indicated she had been busy with another resident this morning and was unable to complete these tasks on time. LPN #8 called the physician at 10:30 A.M. and obtained an order to hold the Lantus insulin dose for 8/18/14 and resume Lantus insulin on 8/19/14. Resident #92 was administered 10 units of Novolog insulin at 10:45 A.M. During an interview with Resident #92 on 8/18/14 at 11:05 A.M., Resident #92 said, "I waited for awhile this morning and did not eat, but the nurse was busy so I went ahead and ate my breakfast. I ate biscuits,gravy and eggs. I know it will make my numbers go up. My blood sugar should be checked in the morning before I go to breakfast and my insulin should be given before breakfast." The clinical record of Resident #92 was reviewed on 08/18/14 at 9:30 A.M. The record indicated the diagnoses of Resident #92 included, but were not limited to, insulin dependent diabetes mellitus. The most recent Physician Order Recap dated 08/2/14 included, but was not limited to, orders for, "...Accuchecks Twice Daily...07:30 (7:30 A.M.) ...		below 100%. Compliance date 09/18/14	

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	Lantus Inj Solostar inject 10 units ...every morning...0730...Novolog inj FLEXPEN Inject subcutaneously per sliding scale: every morning and evening...201-225=10 units..." The Nursing 2001 Drug Handbook 34th edition, page 748, read as follows: "Novolog...Give 5 to 10 minutes before start of meal..." The Policy and Procedure "Diabetes -Clinical Protocol" provided by the DON (Director of Nursing) on 08/19/14 at 3:08 P.M. indicated, "...2. the Physician will order appropriate lab test ...(periodic finger sticks)...and adjust treatments based on the results...a...(3) For the resident receiving insulin...monitor blood glucose levels twice a day if on insulin... (for example, before breakfast and lunch and as necessary)...monitor 3 to 4 times a day if on...sliding scale..." During an interview on 8/19/14 at 3:37 P.M., LPN #15 indicated Accuchecks (blood sugar checks) and insulin administration should be completed before meals. During an interview on 8/19/14 at 3:41 P.M., the Director of Nursing (DON), indicated glucometer checks (blood sugar levels) should be done before meals			

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	because the sliding scale for Novolog is based on the blood sugar level. 3.1-48(c)(2) 3.1-25(b)(9)			
F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package			

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	drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review the facility failed to return and/or dispose of discontinued and/or expired medications in a timely manner for 1 of 2 medication carts observed and 1 of 1 medication storage rooms observed located on the 100 hall in that, discontinued and/or expired medications were kept in the facility past 7 days and the facility failed to store a medication which had a high likelihood of abuse securely behind 2 locks in 1 of 1 medication storage rooms reviewed on the 100 unit. (Resident #101, Resident #154) Findings Include: 1. On 8/19/14 at 11:24 A.M., an observation of the facility medication storage room was completed with LPN Unit Manager #1 (UM #1). During the observation the following medications were observed in the refrigerator: Six vials of Flulaval (an injectable influenza vaccination) with an expiration date of June 2014 on all boxes. Six vials of Fluzone (an injectable influenza vaccination) with an expiration date of June 30, 2014 on all of the boxes. An open vial of Lorazepam Intensol Oral	F000431	F431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS All vials of influenza vaccination found to be expired were disposed of immediately. The medication room refrigerator had a lock installed immediately for a double locking system. The Fluocinonide 0.5% solution was immediately disposed of. All medication carts and medication room (including the refrigerator) were audited during the survey process for any expired medications, proper storage of medications with a high likelihood of abuse and discontinued medications and no other concerns were noted. The Systemic change includes a "Cart Captain Program" will be initiated, in which a designated Nursing Administrative person reviews all medication carts and medication storage areas for expired, discontinued or storage of a controlled substance in a double locked area is completed weekly. In addition, all new orders are reviewed at the daily clinical meeting. Any order for a discontinued medication will be monitored for timely destruction	09/18/2014

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	Concentrate (an anti anxiety medication) belonging to Resident #154 sitting on the bottom shelf of the unlocked refrigerator. No lock box and no locking mechanism were observed on the refrigerator. During an interview with UM #1, at that time, she indicated that narcotic medications stored in the medication storage room did not have to be stored under double lock and key. She confirmed the 12 boxes of influenza vaccination was expired. 2. On 5/19/14 at 11:40 P.M., the medication cart for the 100 hall was observed with RN #10. During the observation, an opened box of Fluocinonide 0.05% solution belonging to Resident #101 a topical corticosteroid (used to treat itching and inflammation) was observed to be dated 3/28/14. RN #10 indicated at that time there was no current order for this medication and she was unsure when it was discontinued. Documentation was lacking as to when the medication had been discontinued. An undated policy titled "Drug Storage" was provided on 8/19/14 at 12:00 P.M., by Regional Nurse Consultant #5. The policy included "...9. Discontinued and expired medications should be removed from medication carts, refrigerators and cupboards promptly. Return drugs or		within 7 days. Education will be provided to licensed nurses regarding the Cart Captain Program and proper medication storage, including storage of controlled substances with a double lock (including the new lock on the medication room refrigerator), and timely destruction (within 7 days) of expired and or discontinued medications. The Unit Manager or designee will complete a QA Audit tool to monitor medication carts and medication room (including locking of the refrigerator) for expired medications and timely disposal of medications (within 7 days). The audit tool will include destruction of any medication discontinued as discussed the daily clinical meeting. This audit will be completed daily for 30 days, then weekly for 30 days, then every other week for 4 months, then monthly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 09/18/14	

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	destroy according to pharmacy and facility policies. Discontinued drug containers shall be marked to indicate that the drug has been discontinued ... " The policy also included " ...10. All Class II drugs must be stored under **double lock** [sic] at all times. (Pharmacy name) recommends that Class III, IV and V drugs are also stored under double lock as a best practice guideline. " An undated policy titled " Drug Disposal " was provided on 8/19/14 at 2:41 P.M., by Regional Nurse Consultant #5. The policy included, " Discontinued drugs or those that remain in the facility after a resident ' s discharge or death (that are not house supplied or returned for credit) are to be destroyed by the facility. " On 8/19/14 at 3:43 P.M., the Director of Nursing (DON) was interviewed, she indicated narcotics had to be disposed of within seven days of discontinuation but she was unsure of a time frame for other medications. 3.1-25(n) 3.1-25(o) 3.1-25(r)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. Based on interview, and record review, the facility failed to ensure the clinical record was complete and/or accurately documented, in that, medication records related to the administration of as needed pain and/or hypnotic medication and/or insulin were not complete and/or accurate for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #66, Resident #4) Findings include: 1. The clinical record of Resident #66 was reviewed on 08/18/14 at 3:00 P.M. The record indicated the diagnoses of Resident #66 included, but was not	F000514	F514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE Resident #66 is receiving her insulin, prn pain medication and respiratory treatments per physician order and documentation is complete and accurate in the medical record. Resident #4 now has her hypnotic ordered routinely and documentation is complete and accurate in the medical record. All residents with as needed pain and/or hypnotic medication and/or insulin orders have been identified and documentation will be reviewed	09/18/2014

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	limited to, exacerbation of COPD (Chronic Obstructive Pulmonary Disease), Pneumonia (a pulmonary infection), diabetes, diabetic neuropathy, and chronic pain. The Admission MDS (Minimum Data Set Assessment) dated 05/09/14 indicated Resident #66 experienced moderate cognitive impairment, no episodes of care rejection, experienced frequent pain, and received insulin daily. The most recent Quarterly MDS dated 06/13/14 indicated Resident #66 experienced minimal cognitive impairment, no episodes of care rejection, experienced frequent pain, and received insulin daily. The most recent Physician's Order Recap dated 07/16/14 included, but was not limited to, orders for: "...Lantus (a slow-acting insulin)...inject 45 units subcutaneously every morning and evening... ...Novolog inject (a fast-acting insulin)...per sliding scale before meals 151-200-10 units; 251-300=18 units; 201-250=14 units; 301-350=20 units;		for accuracy and complete documentation in the medical record for the last 30 days. All concerns will be addressed. The systemic change includes: · Licensed nurses and QMAs will complete a competency check regarding accuracy and documentation in administration of as needed pain and/or hypnotic medication and/or insulin. This competency check will also be completed upon hire of new nurses. · Licensed nurses and QMAs will complete a check of the MAR at change of shift for any holes in the documentation. This will be completed between the on-coming nurse/QMA with the off-going nurse/QMA to review any concerns with documentation of medication administration. Education will be provided to licensed nurses and QMAs regarding accurate and complete documentation in the medical record for as needed pain and/or hypnotic medication and/or insulin orders. The DON or designee will complete a QA audit tool monitoring documentation of a pain assessment prior to and after administration of a prn pain medication as well as follow up documentation of effectiveness	

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	>(greater than) 351=22 units and call MD:...7:30 A.M....11:30 A.M.....4:30 A.M... ...Novolog inject...per sliding scale: at bedtime: 71-200= 0 units 201-250=2 units; 251-300=4 units; 301-350=5 units; 351-400=6 units; >401=7 units and call MD (physician)...Check blood sugar before meals and at bedtime call MD<(less than) 60 or > 400... ...Albuterol neb (nebulizer) ...one vial per nebulizer every 8 hrs (hours) while awake (0600, 1400, 2200)..." A Physician's Telephone Order dated 07/16/14 indicated a new order was received for, "...increase Lantus by 4 units from current dose..." A Controlled Drug Record dated 08/08/14 through 08/14/14 indicated Resident #66 received Percocet on the following dates: 08/07/14 at 8:00 P.M. 08/08/14 at (illegible) 08/08/14 at 11:00 A.M. 08/09/14 at 6:00 A.M. 08/10/14 at 1:00 P.M.		of the medication. In addition, the QA auditing tool will include monitoring of documentation of an intervention attempted prior to administration of a prn hypnotic as well as documentation of the effectiveness. The tool will also include accuracy of documentation of insulin and respiratory treatments. This auditing will be completed daily (including weekends) for 30 days, weekly for 5 months and then monthly for an additional 6 months for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 09/18/14	

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	08/11/1 4 at 4:00 P.M. 08/13/14 9:30 P.M. 08/14/14 at 4:00 A.M. 08/14/14 at 8:30 P.M. The August 2014 MAR lacked any documentation Resident #66 had received Percocet on the following dates: 08/08/14 at 11:00 A.M. 08/09/14 at 6:00 A.M. 08/14/14 at 10:30 P.M. The August 2014 MAR lacked any documentation Resident #66 received 49 units of Lantus insulin on the following dates: 08/03/14 at 4:30 P.M. 08/06/14 at 7:30 A.M. 08/09/14 at 07:30 A.M. The August 2014 MAR lacked any documentation Resident #66 received Novolog insulin per sliding scale on the following dates: 08/04/14 at 11:30 A.M. for Accucheck result of 244 mg(milligram)/dl (deciliter). (14 units of Novolog should have been administered) 08/05/14 at 7:30 A.M. for Accucheck result of 179 mg/dl (10 units of Novolog should have been administered)			

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	08/07/14 at 7:30 A.M. for Accucheck result of 222 mg/dl (14 units of Novolog should have been administered) 08/08/14 at 7:30 A.M. Documentation was lacking an Accucheck result. 08/09/14 at 7:30 A.M. Documentation was lacking an Accucheck result. 08/10/14 at 4:30 P.M. for Accucheck result of 176 mg/dl. (10 units of Novolog should have been administered) 08/12/14 at 7:30 A.M. for Accucheck result of 267 mg/dl (18 units of Novolog should have been administered) 08/12/14 at 11:30 A.M. for Accucheck result of 231 mg/dl (14 units of Novolog should have been administered) 08/16/14 at 8:30 P.M. Documentation was lacking an Accucheck result. The PRN (as needed) Pain Assessment Monitoring Form dated 08/01/14 through 08/14/14 lacked any documentation Resident #66 received Percocet on the following dates: 08/08/14 at 11:00 A.M. 08/09/14 at 6:00 A.M. 08/14/14 at 10:30 P.M.			

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	The PRN (as needed) Pain Assessment Monitoring Form dated 08/01/14 through 08/14/14 indicated Resident #66 received Percocet without follow up assessment on the following dates: 08/01/14 at 1:30 P.M. 08/02/4 at 9:00 P.M. 08/06/14 at 7:30 P.M. 08/10/14 at 9:00 P.M. 08/14/14 at 2:00 P.M. The PRN Pain Assessment Monitoring form dated 08/01/14 through 08/14/14 lacked any documentation a pain assessment was completed before the administration of Percocet on the following dates: 08/07/14 at 8:00 P.M. 08/08/14 at (unknown time) 08/08/14 at 11:00 A.M. 08/09/14 at 6:00 A.M. 08/10/14 at 1:00 P.M. 08/11/14 at 4:00 P.M. 08/13/14 at 9:30 P.M. 08/14/14 at 4:00 A.M. 08/14/14 at 8:30 P.M. The August 2014 Respiratory Therapy Worksheet lacked any documentation Resident #66 received a breathing treatment on the following dates: 08/04/14 at 2:00 P.M. 08/06/14 at 2:00 P.M. 08/06/14 at 10:0 P.M.			

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	08/07/14 at 2:00 P.M. 08/10/14 at 2:00 P.M. 08/11/14 at 10:00 P.M. 08/12/14 at 6:00 A.M. 08/13/14 at 2:00 P.M. 08/14/14 at 2:00 P.M. 08/14/14 at 10:00 P.M. 08/17/14 at 2:00 P.M. The August 2014 MAR lacked any documentation Resident #66 received a breathing treatment on the following dates: 08/04/14 at 2:00 P.M. 08/06/14 at 2:00 P.M. 08/06/14 at 10:0 P.M. 08/07/14 at 2:00 P.M. 08/10/14 at 2:00 P.M. 08/11/14 at 10:00 P.M. 08/12/14 at 6:00 A.M. 08/13/14 at 2:00 P.M. 08/14/14 at 2:00 P.M. 08/14/14 at 10:00 P.M. 08/17/14 at 2:00 P.M. During an interview on 08/19/14 at 3:00 P.M. The DON (Director of Nursing) indicated a Controlled Drug Record from 08/01/14 through 08/07/14 could not be located. The DON further indicated, at that time, an accurate accounting of Percocet, Lantus, Novolog, and Albuterol administration for Resident #66 could not			

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	be provided from 08/01/14 through 08/14/14 because documentation was not complete. The DON then indicated, the nursing staff was expected to document completely and accurately. 2. The Clinical Record for Resident #4 was reviewed on 8/14/14 at 10:01 A.M., diagnoses include, but were not limited to, hypertension, dementia and anxiety. The care plans included, but were not limited to, use of antipsychotic and hypnotic medication. The signed physician's order dated July 2014 included, but was not limited to, Zolpidem (a hypnotic drug) one tab at bedtime as needed (PRN) for insomnia starting on February 2nd, 2014 The Controlled Drug Record for the administration of Zolpidem was reviewed on 8/18/14 at 12:36 P.M., it indicated Resident #4 had received the medication on the following dates 8/1/14 at 1900 (7:00 P.M.) 8/2/14 at 20:30 (8:30 P.M.) 8/3/14 at 19:00 (7:00 P.M.) 8/4/14 at 20:30 (8:30 P.M.) 8/5/14 at 20:00 (8:00 P.M.) 8/6/14 at 20:30 (8:30 P.M.) 8/7/14 at 19:00 (7:00 P.M.) 8/8/14 at 19:00 (7:00 P.M.)			

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	8/9/14 at 19:00 (7:00 P.M.) 8/10/14 at 19:00(7:00 P.M.) 8/11/14 at 20:20 (8:20 P.M.) 8/12/14 at 20:30 (8:30 P.M.) 8/13/14 at 20:00 (8:00 P.M.) 8/14/14 at 19:00 (7:00 P.M.) 8/15/14 at 19:00 (7:00 P.M.) 8/16/14 at 19:00 (7:00 P.M.) 8/17/14 at 19:00 (7:00 P.M.) The "PRN MEDICATION ADMINISTRATION MONITORING FORM" for Resident #4 was reviewed on 8/18/14 at 12:36 P.M. It lacked any documentation of interventions and effectiveness of Zolpidem on following dates: 8/1/14 at 1900 (7:00 P.M.) 8/2/14 at 20:30 (8:30 P.M.) 8/3/14 at 19:00 (7:00 P.M.) 8/4/14 at 20:30 (8:30 P.M.) 8/6/14 at 20:30 (8:30 P.M.) 8/7/14 at 19:00 (7:00 P.M.) 8/8/14 at 19:00 (7:00 P.M.) 8/9/14 at 19:00 (7:00 P.M.) 8/10/14 at 19:00(7:00 P.M.) 8/11/14 at 20:20 (8:20 P.M.) 8/12/14 at 20:30 (8:30 P.M.) 8/13/14 at 20:00 (8:00 P.M.) 8/14/14 at 19:00 (7:00 P.M.) 8/15/14 at 19:00 (7:00 P.M.) 8/17/14 at 19:00 (7:00 P.M.) The medication administration record for			

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	Resident #4 was reviewed. It lacked any documentation of administration of Zolpidem 5 mg on the following dates: 8/1/14 at 1900 (7:00 P.M.) 8/3/14 at 19:00 (7:00 P.M.) 8/7/14 at 19:00 (7:00 P.M.) 8/8/14 at 19:00 (7:00 P.M.) 8/9/14 at 19:00 (7:00 P.M.) 8/10/14 at 19:00(7:00 P.M.) 8/12/14 at 20:30 (8:30 P.M.) 8/13/14 at 20:00 (8:00 P.M.) 8/14/14 at 19:00 (7:00 P.M.) 8/15/14 at 19:00 (7:00 P.M.) 8/16/14 at 19:00 (7:00 P.M.) 8/17/14 at 19:00 (7:00 P.M.) The nursing progress notes for Resident #4 were reviewed. Documentation was lacking in regards to attempted interventions and or effectiveness of any PRN medication administered to Resident #4. During an interview with LPN #4 on 8/18/14 at 10:44 A.M., she indicated that before administration of a PRN medication appropriate non-pharmacological interventions should be documented on the facility " PRN MEDICATION ADMINISTRATION FORM ". She further indicated that after the			

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	administration of a PRN medication the nurse should go back and assess for effectiveness of the medication and document on the form. On 8/19/14 at 9:20 A.M., during an interview, the Director of Nursing was interviewed, she indicated it was the facility policy for nurses to offer and document non-pharmacological interventions prior to the administration of any PRN medication. She further indicated that effectiveness of the medication should be assessed after administration. The facility was unable to provide any further documentation to show that non-pharmacological interventions were attempted and/or effectiveness of the hypnotic medication was being monitored for Resident #4. 3.1-50(a)(1) 3.1-50(a)(2)			