STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155531	A. BUILDING 00 B. WING	04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBROOK VILLAGE	850 ASH ST HUNTINGTON, IN 46750

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 7, 8, 11, 12 and 13, 2016 Facility number: 000569 Provider number: 155531 AIM number: 100267660 Census bed type: SNF/NF: 33 Total: 33 Census payor type: Medicare: 3 Medicaid: 26 Other: 4 Total: 33 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on April 15, 2016.	F 0000	Submission of this Plan of Correction does not constitute anadmission or agreement by the provider of the truth of facts alleged orcorrections set forth on the statement of deficiencies. This Plan of Correctionis prepared and submitted because of requirements under State and Federal law. Pleaseaccept this plan of correction as our credible allegation of compliance.	
F 0248 SS=E Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES			

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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	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to provide an individualized activity program for three of three cognitively impaired residents who were reviewed for activities (Residents #9, #20 and #41). This deficient practice had the potential to affect 14 of 33 cognitively impaired residents who reside at this facility. Findings include: 1. On 4/7/2016 at 10:31 a.m., Resident #20 was asleep in bed holding a baby doll. On 4/8/2016 at 9:31 a.m., Resident #20 was sitting in her wheel chair across from the nurses station. On 4/11/2016 at 10:07 a.m., Resident #20 was sitting near the doorway of the TV room with her head back, eyes closed and arms crossed. Dominoes was observed being played in the activity room. On 4/11/2016 at 11:35 a.m., Resident #20 was sitting in her wheel chair in the TV	F 0248	Residents # 9, 20, and 41 did not experience any negativeoutcomes. The activity programs for eachresident was reviewed and revised if indicated and they are currently receivingindividualized activity programs. All cognitively impaired residents have the potential to beaffected. The activity programs for eachresident was reviewed and revised if indicated and they are currently receivingindividualized activity programs. The Activity Director has been re-educated on the ActivityProgram with a special focus on providing individualized activity programs forall residents including those who are cognitively impaired. A monitoring tool has been implemented. The Administrator or designee will be responsible forcompleting the monitoring tool to ensure cognitively impaired residents arereceiving and attending individualized activities. The monitoring will occur as follows: Daily for two weeks, weekly for two weeks,then monthly thereafter. Should a concern be found, immediate corrective actionwill occur. Results of these reviews andany corrective actions will be	04/22/2016

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	room with her head back and her eyes closed. On 4/11/2016 at 2:08 p.m., Resident #20 was sitting in her wheel chair in the TV room, facing away from the television, with her eyes closed and her mouth open. Bingo was being played in the main dining room at that time. On 4/12/2016 at 9:27 a.m., Resident #20 was sitting in her wheel chair in the TV room with her head down and her eyes closed. On 4/12/2016 at 10:25 a.m., Resident #20 was sitting in her wheel chair in the TV room with her eyes closed. Sorry (board game) was being played in the activity room. On 4/13/2016 at 10:23 a.m., Resident #20 was asleep in bed. Yahtzee (Board Game) was being played in the activity room. During an interview with the Activity Director (AD) on 4/12/2016 at 9:10 a.m., she indicated Resident #20 participated in bingo, nails and group exercise. She further indicated Resident #20 liked cooking club, and said "just give her food and something to read and she will be happy." The AD indicated Resident #20		discussed during the facility's monthly QAmeetings on an ongoing basis for a minimum of six months and the plan adjustedif indicated.	

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	always goes to bingo and participated in all other activities most of the time. She further indicated that Resident #20 does not receive 1:1 visits with her because Resident #20 participated in so many activities. The AD indicated she did ball toss for cognitively impaired residents and "whatever they [the residents] can do." She indicated she had sensory stimulation every day for every resident. The AD indicated sensory stimulation started at 11:30 a.m. each day and involved saying "Hi" to each resident and assisting them down to the dining room for lunch. She further indicated she made sure each resident was alert and oriented before lunch. During an interview with Hostess #75 (Activity Aide) on 4/13/2016 at 9:04 a.m., she indicated Resident #9 and Resident #20 both liked bingo, cookie social, and coffee social. She further indicated that sensory stimulation was for every resident and they each received it every day. Hostess #75 indicated sensory stimulation included the activity staff going into a resident room and asking about their day or how they were doing. She indicated there were four residents who received one to one visits, but that Resident #9 and Resident #20 were not included in that group. Hostess #75 indicated that each resident knew about			

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	daily activities by the activity calendar they received, the board hanging in the hallway near the main dining room, and the announcement that was made prior to each activity. A review of the medical record for Resident #20 began on 4/7/2016 at 3:11 p.m., and indicated her diagnoses included, but were not limited to, Alzheimer's Disease, dementia with behavioral disturbances, weakness and depressive disorder. The most current Minimum Data Set, dated 12/29/2015, indicated Resident #20 was severely cognitively impaired and required extensive assistance for mobility and locomotion. The Activity Quarterly Review for Resident #20, dated 4/1/2016, indicated "Resident does not understand, therefore needs assistance to and from activities." Resident #20's activity preferences included but were not limited to "initiates independent activities, listened to music, participating in favorite activities, being around animals such as pets and doing things with groups of people." The Activity Assessment for Resident #20, dated 12/29/2015, indicated she could participate in activities with assistance of cueing and needed physical			

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	assistance and reminders. It further indicated Resident #20's "Identified Leisure Interests and Hobbies" included, but were not limited to, bingo, dominoes, shopping, newspapers, soap operas, sitcoms, game shows, news, movies, sports and cartoons. The Interdisciplinary Care Plan Conference sheet, dated 3/10/2016, was provided by the AD on 4/12/2016 at 9:48 a.m. It indicated activities were reviewed with a comment written in that indicated Resident #20 "chooses her own activities of choice." The Care Plan Worksheet for Resident #20 was last updated on 4/1/2016 and was provided by the AD on 4/12/2016 at 9:48 a.m. The worksheet indicated during an interview, the resident indicated activities are both very important and somewhat important. Resident #20's preferences included, but were not limited to, "listening to gospel, country, rock and oldies music, being around dogs, doing things with groups of people and doing favorite activities such as 'TV and pets.'" Interventions included, but were not limited to, "offer newspapers and music, invite encourage or assist involvement in social groups of interest such as 'Entertainment.'"			

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	The activity preference sheet indicated it was not important for Resident #20 to keep up with the news or discuss news events of interest during daily care and she did not require modification or adaptations for enjoyment of preferred activities. The care plan for the problem of "Cognitive loss / Dementia" for Resident #20 was provided by the AD on 4/12/2016 at 9:48 a.m. It indicated "the resident suffers from cognitive loss as evidenced by severe impaired cognition due to Alzheimer's dementia...depression...BIMS score = 5." The goal indicated the resident would "demonstrate satisfaction with his/her ability to engage in preferred activities during stay as evidenced by [blank]." Interventions included, but were not limited to, "provide cues and supervision as needed, provide special environmental stimuli and directional markers as indicated and reorient as needed." The activity calendars for Resident #20 for February, March and April, 2016 were provided by the AD on 4/12/2016 at 3:06 p.m., and indicated the activities she participated in included but were not limited to: February: Bingo, Sen Stim and Ball toss March: Cookie Social, Bingo and Sen			

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	Stim. April: Euchre, Bingo and Sen Stim. 2. On 4/07/2016 at 2:37 p.m., Resident #9 was asleep in her recliner with her head down, chin to chest. On 4/8/2016 at 11:38 a.m., Resident #9 was sitting in her wheel chair with her head down, chin to chest. On 4/8/2016 at 9:57 a.m., Resident #9 was sitting in her wheel chair at the nurses station saying "no body takes me anywhere". The DON approached Resident #9 and propelled her wheel chair into the TV room. On 4/8/2016 at 10:05 a.m., Resident #9 was sitting in her wheel chair in the doorway of the TV room and indicated "they brought me this far and left me". On 4/8/2016 at 10:24 a.m., Resident #9 was sitting in her wheel chair in the TV room. She was slumped over to the right with her head hanging down and her eyes closed. On 4/8/2016 at 11:38 a.m., Resident #9 was sitting in TV room in her wheel chair with her head down, chin to chest, and her eyes closed.			

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	On 4/11/2016 at 10:07 a.m., Resident #9 was sitting in her recliner asleep while Dominoes was being played in the activity room. On 4/11/2016 at 11:34 a.m., Resident #9 was sitting in her wheel chair in the TV room sleeping with her head hanging down. On 4/11/2016 at 2:24 p.m., Resident #9 was sitting in the main dining room in her wheel chair with her head hanging down, chin to chest, and her eyes closed. There were two bingo cards in front of her and bingo being played by other residents in the room. Hostess #75 approached the table to see if the resident sitting next to Resident #9 was a winner. There was no interaction between the staff and Resident #9. On 4/12/2016 8:36 a.m., Resident #9 was sitting in her wheel chair in the TV room. On 4/12/2016 at 9:28 a.m., Resident #9 was sitting in the TV room with her head down and her eyes closed. On 4/12/2016 at 10:24 a.m., Resident #9 was sitting in her wheel chair in the TV room facing away from TV. Resident #9 was asleep with her head hanging down, chin to chest. Sorry (Board Game) was			

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	observed being played in the activity room. On 4/13/2016 at 10:23 a.m., Resident #9 was asleep in her recliner. Yahtzee was observed being played in activity room. On 4/13/2016 at 2:10 p.m., during a bingo observation in the main dining room. Hostess #75 (Activity Aide) called out "I 17" the AD leaned down to Resident #9 and indicated to her she had "I -17" on her bingo board. Resident #9 did not respond. The AD indicated again that she had that number. Resident #9 did not respond. The AD then reached over and pulled the red tab down in the "I -17" box on Resident #9's bingo card. During an interview with the AD on 4/12/2016 at 9:10 a.m., she indicated Resident #9 attended bingo, however she did not play. She indicated Resident #9 could not pull the number markers down on the bingo cards. The AD indicated Resident #9 liked to have Kleenex tissues and anything that involved food. She indicated she does not do one to one visits with Resident #9 because she does go out of her room and to activities. The AD indicated she did ball toss for cognitively impaired residents and "whatever they [the residents] can do." She indicated that she had sensory			

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	stimulation every day for every resident. The AD then indicated sensory stimulation started at 11:30 a.m. each day and involved saying "Hi" to each resident and assisting them to wheel down to the dining room for lunch. She further indicated she made sure each resident was alert and oriented before lunch. During an interview with Hostess #75 on 4/13/2016 at 9:04 a.m., she indicated Resident #9 and Resident #20 both liked bingo, cookie social and coffee social. She further indicated that sensory stimulation was for every resident and that they receive it every day. Hostess #75 indicated sensory stimulation was going into a resident room and asking about their day or how they were doing. She indicated there were four residents who receive one to one visits, but that Resident #9 and Resident #20 were not included in that group . Hostess #75 indicated that each resident knows about daily activities by the activity calendar they received, the board hanging in the hallway near the main dining room and the announcement made prior to each activity. A review of the medical record for Resident #9 began on 4/8/2016 at 9:48 a.m., indicated her diagnoses included but were not limited to Dementia,			

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	macular degeneration and depressive disorder. The most current minimum data set (MDS) indicated Resident #9 was severely cognitively impaired and required extensive assistance for mobility and locomotion. The Activity Quarterly Review for Resident #9, dated 1/29/2016, indicated Resident #9 could participate in activities with assistance and cueing, however she needed reminders. Resident #9's activity preferences were listed as bingo, group exercise, nails, ball toss, cookie social, cooking club, and church. An Activity Progress Note for Resident #9 was dated 10/15/2015. It indicated "Res [Resident] gets confused easily therefore needs step by step directions...." The Annual Activity Assessment for Resident #9, dated 2/26/2016, indicated her physical condition was fair, she used hearing aids, reading glasses and Resident #9 was alert to self. Resident #9 was able to participate in activities with reminders and was active at times. It also indicated Resident did not need physical or visual assistance for activities. Goals listed included but were not limited to "stop by and say hi". There were no activities of interest identified on the assessment.			

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The Interdisciplinary Care Plan Conference record for resident #9, dated 3/17/2016, indicated Resident #9 "chooses own activities of choice."

The Care Plan Worksheet for Resident #9 was last updated on 3/17/2016 and was provided by the Activity Director on 4/12/2016 at 9:48 a.m. It indicated during an interview the resident indicated activities were both very important and somewhat important. Resident #9's preferences included but were not limited to "having books, news paper and magazines to read, listening to oldies, gospel, and county music, being around animals such as pets, having Kleenex tissues with her and sitting in the front lobby." Interventions included but were not limited "to discuss news during daily care, offer music, provide materials, setting, encouragement, modification or adaptations for enjoyment of preferred activities including but not limited to 'Kleenex.'"

A care plan for the problem of "Cognitive loss/ Dementia" for Resident #9 was updated on 3/17/2016 and provided by the AD on 4/12/2016 at 9:48 a.m. It indicated "the resident suffers from cognitive loss as evidenced by BIMS, severely impaired cognition due to:

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	Dementia...hearing loss BIMS score = 5." Interventions included, but were not limited to, "provide special environment stimuli and directional markers as indicated, reorient as needed." A care plan for the problem of "Communication" for Resident #9 was updated on 3/17/2016 and provided by the AD on 4/12/2016 at 9:48 a.m. It indicated "the resident has difficulty understanding others d/t [due to]: difficulty hearing...." Interventions included but were not limited to "use questions requiring a yes/no answer when appropriate." A care plan for the problem "Visual Function" for Resident #9 was updated 3/17/2016 and provided by the AD on 4/12/2016 at 9:48 a.m. It indicated "The resident has decreased vision: unable to read fine print, macular degeneration, medication use, age." Interventions included but were not limited to "provide activities appropriate for the resident and assist and encourage resident to attend activities of choice." The activity attendance calendars for February, March, and April, 2016 for Resident #9 were provided by the Activity Director on 4/12/2016 at 3:06 p.m. It indicated the activities she			

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	participated in included but were not limited to: February: Coffee Club, Sen Stim, Ball Toss March: Church, Sen Stim, bingo, and popcorn April: Aggravation (Board Game) Coffee Club, Sen stim, bingo, and group exercise. 3. On 4/07/16 at 10:32 a.m., Resident #41 was sleeping in her recliner. Her TV was playing Sesame Street. On 4/07/16 at 12:28 p.m., Resident #41 was being propelled in her wheelchair to her room by LPN #25 following lunch. On 4/07/16 at 2:02 p.m., Resident #41 was in bed asleep. Her TV was playing a Curious George cartoon. On 4/08/16 at 10:32 a.m., Resident #41 was in bed asleep. On 4/11/16 10:03 a.m. Resident #41 was in bed asleep. Her TV was playing Sesame Street. On 4/11/16 at 11:38 a.m., Resident #41 was being propelled in her wheelchair to the dining room by LPN #26. At 11:44 a.m., the resident was seated at the dining			

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	table with her head back and eyes closed. Hostess #15 was passing hot drinks to the residents in the dining room. On 4/11/16 at 1:47 p.m., Resident #41 was being propelled by her daughter to the dining room for bingo. At 2:21 p.m., Resident #41 was in her wheelchair at a table in the dining room with four bingo cards in front of her. Her daughter was sitting next to her marking the four bingo cards. Resident #41's eyes alternated between closing for extended periods of time and looking around room and her hands were at the the sides of her legs, resting on the seat of her wheelchair. Resident #41 was not participating in the game. At 2:26 p.m., Resident #41 won bingo as she was asleep in her wheelchair, with her hands remaining at the sides of her legs. On 4/12/16 at 1:27 p.m., Resident #41 was in bed asleep as the "Cookie Social" took place in the main dining room. On 4/12/16 at 2:52 p.m., Resident #41 was in bed staring at the ceiling. The TV was playing a Curious George cartoon. On 4/13/16 at 10:08 a.m., Resident #41 was in bed asleep. The TV was playing Sesame Street.			

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	On 4/13/16 at 11:30 a.m., Resident #41 was in her wheelchair in the lounge with a group of six other residents, with the TV playing a game show. Staff members were coming in and assisting the residents to the dining room one at a time. Resident #41 was looking below the TV, toward the lounge window. Review of Resident #41's clinical record began on 4/7/16 at 11:03 a.m. Diagnoses included, but were not limited to, dementia and depression. Resident #41 had a current, 3/26/16, annual Minimum Data Set Assessment(MDS) which indicated the resident required cues and supervision with decision making. The assessment further indicated she rarely/never understood others, was rarely/never understood by others, and required total assistance with wheelchair locomotion. Review of activity assessment documents, dated 3/26/16, indicated Resident #41 was alert and able to choose activities "of choice". Interventions included "stopping by to say hi, provide and review calendar as needed, and remind and assist to special events." The activity assessment indicated Resident #41 was able to participate in			

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	activities with assistance and cueing with physical assist, verbal assist, and reminders. Review of the document indicated Resident #41 understood the activities, did not require assistance, and was interested and responsive during the activities. The assessment further indicated the resident was an active participant in activities at times, and did not passively participate nor required encouragement. Resident #41's leisure interests included, but were not limited to, bingo, parties, music, television, and talking/conversing with others. Resident #41 had a current activities careplan worksheet for activities preferences. The careplan indicated Resident #41 responded during an interview that activities were both very important and somewhat important to her while in the facility. The careplan indicated the resident enjoyed, but was not limited to, "reading books, newspapers, letters, and magazines." The careplan further indicated she also enjoyed being around groups of peers. Interventions included, but were not limited to, "providing reading materials, offering music, and inviting, encouraging, and assisting to social groups." The careplan indicated Resident			

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	#41 did not require modification or adaptations for the enjoyment of her preferred activities. Resident #41 had a current careplan problem of decreased vision. The careplan specified the resident was unable to participate in vision testing. Resident #41 had a current careplan problem of progressive cognitive and communicative deficits with dementia, decreased communication abilities, highly impaired hearing, and impaired vision. Interventions included, but were not limited to, "using simple, direct statements, using questions that required a yes/no answer, and anticipating resident needs." Review of an Activity Log for April 1 through April 11, 2016 indicated Resident #41 attended and participated in, but not was limited to, the following activities: group exercise, bingo, and cookie club. The log also indicated the resident attended and participated in sensory stimulation five days a week. Review of an Activity Log, dated March, 2016, indicated Resident #41 attended and participated in, but was not limited to, the following activities: bingo, ball toss, fancy nails, coffee club, and cookie			

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	social. The log also indicated the resident attended and participated in sensory stimulation five days a week. Review of an Activity Log, dated February, 2016, indicated Resident #41 attended and participated in, but was not limited to, the following activities: bingo, ball toss, fancy nails, coffee club, and cookie social. The log also indicated the resident attended and participated in sensory stimulation five days a week. During an interview, on 4/12/16 at 8:58 a.m., with the Activities Director (AD) and Office Manager (who the AD identified as the Social Services trainer), they indicated Resident #41 participated in the following activities: bingo, church, group exercise, ball toss, outside visit (going outdoors starting in April), cookie social, cooking club, fancy nails, entertainment, and special events. The AD indicated Resident #41 needed to "really be encouraged", "doesn't really participate" in activities, and would "people watch". When asked if Resident #41 was cognizant of her surroundings, they indicated she was "fifty-fifty". The AD indicated Resident #41 actively participated in bingo although she was not able to see the numbers, but if the AD			

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	would point at the card, Resident #41 would move the plastic piece on the card. She indicated Resident #41 actively participated in coffee club as she was able to feed herself with one hand, and could lightly raise one hand during group exercise. She further indicated Resident #41 would get her fingernails painted sometimes during fancy nails. The AD indicated that "Sensory Stimulation" consisted of "saying hi" to each resident in the facility every day. She also indicated four residents in the facility received one-to-one visits, but were more for residents that did not leave their rooms very often. She indicated she only kept records of the one-to-one visits. On 4/12/16 at 11:11 a.m., Hostess #75 (Activity Aide) indicated "Sensory Stimulation" scheduled five days a week consisted of "touching base" with each resident daily. She indicated she handled most of the board game activities and bingo, while the AD oversaw the cookie and coffee socials. On 4/13/16 at 8:08 a.m., QMA #3 indicated Resident #41 laid down after every meal in either her bed or her recliner. On 4/13/16 at 10:44 a.m., CNA #12			

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	indicated Resident #41's daughter was watching PBS programming in the evenings and the TV just gets left on PBS during the day while the resident was in her room. Review of a policy titled, "Residents With Special Needs", dated November 2008, and provided by the Social Services Consultant on 4/12/16 at 10:30 a.m., indicated the following: "...It is the policy of this facility to: 1. Provide activity programs and modified interventions to promote the maintenance or enhancement of each resident's quality of life, and to promote physical, cognitive, and/or emotional health to the extent practicable. 2. Offer meaningful activity programs for residents who have disorientation to time, place, and/or person. 3. Provide activity programs to reflect the resident's individual needs, to enhance and promote each resident's physical and mental status, and promote cognitive health... ...The Activity Director/staff will: 1. Identify the resident's individual			

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	physical, emotional, or mental challenges within the resident assessment process... ...4. ...determine whether the resident could benefit from the adapted or modified activity programs to meet his or her individual needs... ...7. Solicit family and staff support to help reinforce important information so that the resident will have constant reminders and cues from others on the material and information covered in the program. 8. Modify activity programs to promote each resident's meaningful participation by simplifying steps, adapting approaches, and modifying instructions...." 3.1-33(a)			
F 0425 SS=D Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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.			

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	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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to have available prescription narcotic pain medications for a resident admitted for rehabilitation following total knee replacement with two prescriptioned narcotic pain medications on admission to the facility. (Resident #35) Findings include: The closed clinical record for Resident #35 was reviewed on 4/11/16 at 10:49 a.m. Diagnoses for the resident included, but were not limited to, left total knee replacement, degenerative joint disease, congestive heart failure, diabetes mellitus and hypertension. A review of Resident #35's physician orders indicated the following: a. A copy of two hard prescriptions from the Orthopedic physician, dated 2/9/16,	F 0425	Resident #35 was rehabilitated by the facility anddischarged home prior to this survey. The narcotic pain medications for this resident arrived the day afteradmission. Prior to receiving thenarcotic pain medications, the resident was offered Tylenol per MD orders andthis was refused by the resident. All residents have the potential to be affected. Their clinical records have been reviewed forthe past 30 days and there were no occurrences of missing medications. The DON and nurses have been educated on obtainingmedications from the pharmacy with a special focus on procedure for obtainingnarcotic pain medications. A monitoringtool has been implemented. The DON or designee will be responsible for reviewing themedication and treatment administration records and completing the monitoringtool to	04/22/2016

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	for "...Percocet 5/325 [milligrams] 1-2 tabs po [by mouth] q [every] 6 hrs [hours] prn [as needed] [for] pain #80 [80 tablets]...and...oxycontin [OxyContin] 10 mg [milligrams] 1-2 tabs po [by mouth] q [every] 12 hrs prn [as needed] pain #40 [40 tablets]...." b. A telephone clarification physician order, dated 2/11/16 at 4:30 p.m., for the following: "...1) Oxycontin 10 mg [milligrams] [1 tablet] po [by mouth] Q [every] 12 hrs [hours] PRN [as needed] [for] Pain...2) Percocet 5-325 mg [2 tablets] po [by mouth] Q [every] 6 hrs PRN [for] Breakthrough Pain...." c. The physician orders, dated 2/11/16 through 2/29/16, also included "...Tramadol 50 mg [1 tablet] po Q 6 hrs PRN [for] mild pain...and...Tylenol 325 mg tablets [2 tablets] po Q 4 hrs PRN [for] Temp [temperature] > [greater than] 100 [Fahrenheit] or pain...." The physician orders further indicated Resident #35 was admitted on 2/11/16 at 3:00 p.m. A review of Nurse's Notes for Resident #35 indicated the following: "...2/11/16 [at] 6:30 p.m. Res [resident] arrived to facility @ [at] 3 p.m. ...A & O [alert and oriented] very pleasant et [and]		ensure all medications and treatments are obtained timely, includingnarcotic pain medications. This monitoring will be completed on scheduled workdays as follows: Daily for two weeksthen weekly thereafter. Should a concernbe found, immediate corrective action will occur. Results of these reviews and any correctiveactions will be discussed during the facility's monthly QA meetings on anongoing basis for a minimum of 6 months and the plan adjusted if indicated.	

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	cooperative... Res being admitted for rehab [rehabilitation] to home d/t [due to] left total knee replacement, day 3 post op [operation] @ [at] this time...Clarification orders received et noted...Able to voice needs...." "...2/12/16 [at] 3 a.m. Res A & O x [times] 3 [person, place and time], upset that her narcotic pain meds [medications] are not available. Writer explained...to res why her pain meds were not here et offered res [resident] her PRN [as needed] Tylenol [with] res refusing. Writer explained to res that pharmacy will receive the hard copy of her narcotic scripts in the morning when they open et staff can then call et get an authorization to remove her meds from our EDK [emergency drug kit] Res still not happy, yelling @ writer to 'borrow from someone then replace it!' Writer explained to res that 'I'm not allowed to do that.' Res then demanded writer to 'call the hospital administrator' et our administrator. Writer explained that the hospital can't do anything @ this point D/T discharging her to our facility. Writer also explained that our administrator can't do anything either, that not even I as a nurse can do anything until [after] 8 a.m. when one of the pharmacist has her actual Rx [prescription]. Writer again offer res			

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	Tylenol to possibly help dull the pain [with] res yelling @ writer 'what is Tylenol going to do?' Then res propelled herself in her w/c [wheelchair]...to her room...trace amt [amount] of edema noted to LLE [left lower extremity]...Surgical incision to L [left] knee... Res able to make needs known to staff...." "...2/12/16 [at] 11 a.m. ...Earlier teary eyed et c/o [complain of] much pain. Since has had an oxycontin [OxyContin] et assessed resting comfortably... [no] further c/o pain since oxy was given...." A review of the "PRN [as needed] MEDICATION FLOWSHEET" for Resident #35 for February, 2016 indicated the following: "...Pain as described by the resident: ("0" = no pain: "10" = worst pain you can imagine). "...2/11 [2016] [at] 8 p.m. c/o knee pain of an 8...Tylenol 325 mg [milligrams] [2 tablets] po [by mouth] and indicated was effective at 9:12 p.m...." "...2/12 [2016] [at] 8 a.m. [resident] c/o knee pain of 10...Tylenol 325 mg [2 tablets] po and indicated was not effective at 9:30 a.m...."			

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	"...2/12 [2016] [at] 10:45 a.m. [resident] c/o knee pain of "15"...Oxycontin 10 mg [milligrams] [1 tablet] po and indicated was effective at 12 N [noon]...." During an interview with the Director of Nursing (D.O.N.) on 4/11/16 at 2:13 p.m., she indicated the facility had a problem related to obtaining an authorization for prescription narcotic medications for residents, so she was now an authorized representative for both medical directors which allowed her to give authorization for new and refills on narcotic medications. The D.O.N. further indicated that something had to be given for the residents who needed their pain medications. She indicated the first prescription that she had completed as a representative was completed on 2/12/16. The D.O.N. indicated she could not remove any medication from a narcotic EDK without an authorization number. She indicated the only way to get an authorization number for a hard prescription slip was to be in the presence of a pharmacist or the physician would need to call the pharmacist and give the order over the phone. The D.O.N. indicated Resident #35 had hard prescription slips for pain medications and they were scheduled II narcotics.			

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	The D.O.N also indicated when the facility received a telephone order, they would fax it to the facility pharmacy, then the facility pharmacy would generate a form that would be sent to the physician to sign. If the physician did not sign the form, then it was sent to the facility to the D.O.N. The D.O.N. indicated since she was an authorized representative, she would complete the form and send the form to the physician's office for his signature by either fax or drive it over to the office. During an interview with the D.O.N. on 4/11/16 at 3:40 p.m., she indicated when the nurse contacted the physician for clarification on the prescription narcotic pain medication for Resident #35, she would assume the physician would have known that he would need to call the facility pharmacy to give authorization to be able to dispense the prescription pain medication sooner. A review of the Nurse's Notes, from 2/11/16 to 2/13/16, for Resident #35 indicated no request to the physician for the prescription narcotic pain medications to be dispensed sooner. During an interview with the D.O.N. on 4/12/16 at 8:57 a.m., she indicated if a			

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	resident's pain was severe, the facility would have to send the resident out to the emergency room for pain management, because the facility would not be able to get the prescription narcotic pain medication without prior authorization. During an interview with the D.O.N. and Nurse Consultant on 4/12/16 at 9:40 p.m., the D.O.N. indicated the physician knew that he would need to call the facility pharmacy to have the prescription narcotic pain medication dispensed sooner. During an interview with the facility pharmacy's controlled substance manager on 4/13/16 at 1:51 p.m., she indicated the facility pharmacy was a resale pharmacy. She also indicated a hard copy of the prescription narcotic pain medication had to be in the presence of the pharmacist, same as at the local pharmacies. The Controlled Substance Manager indicated an additional option the facility had would be to take the hard copy to the local pharmacy. The facility would contact the facility pharmacy and the facility pharmacy would then contact the local pharmacy with the billing information for the resident's medication. During an interview with the D.O.N. on 4/13/16 at 2:10 p.m., she indicated the			

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	facility's backup pharmacy was a local pharmacy in town. The pharmacy was open until 9 p.m. She further indicated it was not policy to go to the local pharmacy to obtain a prescription narcotic pain medication. A review of the narcotic emergency drug kit contents label provided by the D.O.N on 4/13/16 indicated OxyContin 10 mg tab and Percocet 5/325 tab were available in the kit. A review of an undated policy titled "CONTROLLED DRUGS" provided by the D.O.N on 4/11/16 at 3:25 p.m., indicated the following: "...POLICY ...Drugs listed in Schedule II through V of the Controlled Substances Act possess high abuse potential and are subject to special handling, storage, disposal, and recordkeeping. ...PROCEDURES ...4. By law, Schedule II controlled drugs may be dispensed by the pharmacy only upon receipt of a properly executed prescription written by the resident's attending physician. In an emergency situation, the pharmacist may accept a telephone order directly from the prescribing physician (not nurse) for not more than a			

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	155531	A. BUILDING 00 B. WING	04/13/2016

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	seventy-two (72) hours supply of Schedule II drug. By law also, the prescriber must send the pharmacy supplier a follow-up written prescription for the emergency supply within seventy-two (72) hours. A review of an undated "INNOVATIVE PHARMACY NARCOTIC EDK PROCEDURES" provided by the D.O.N. on 4/11/16 at 3:25 p.m., indicated the following: "...EDK USAGE AUTHORIZATION...ALL NARCOTIC MEDICATION REQUIRES AUTHORIZATION FROM THE PHARMACY PRIOR TO REMOVAL. THE PHARMACY MUST HAVE A VALID PRESCRIPTION ON FILE BEFORE MEDICATION IS REMOVED. ...2. Facility will notify practitioner of patient if no prescription is on file. 3. Practitioner will contact pharmacy or on-call pharmacist to fax or phone in prescription. 4. Pharmacist will call back to facility with authorization number to allow nurse to remove approved medication...." A review of policy titled "CONTROLLED SUBSTANCE POLICY AND PROCEDURE" with a			

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	revision date of 01/13/2012 provided by the D.O.N. from the facility pharmacy indicated the following: "...Procedures: The pharmacy will require one of the following for CII [controlled Scheduled II] prescriptions prior to dispensing: 1. A valid hard copy of the prescription signed and dated by the prescribing physician. a. The blue, prescription pad hard copy (a fax of this from the facility is not legal) b. A fax of the blue, prescription pad hard copy from the physician's office to Innovative Pharmacy Solutions with "Prescription valid only if transmitted by fax to Innovative Pharmacy Solutions" written at the top of the prescription. This is only legal when faxed from office to pharmacy. Not legal when faxed from the facility to the pharmacy. c. A fax of the prescription, signed and dated by the physician, written from the controlled substance book that was provided by Innovative Pharmacy Solutions for physician use when in the facility. 2. A verbal, emergency supply prescription, from the prescribing physician with the understanding that a signed prescription for the emergency supply is due within 7 days. The			

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	pharmacy will fax the physician for the emergency supply signature..." 3.1-25(a)			
F 0431 SS=D Bldg. 00	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 ensure a medication cart was locked while unattended in the hallway. This deficient practice had the potential to affect 10 cognitively impaired residents who resided on the 200 hallway. Findings include: During an observation of the 200 hall way on 4/11/2016 at 1:56 p.m., an unlocked and unattended medication cart was in the 200 Hall. LPN #76 was observed walking by the unlocked cart two times. Respiratory Therapy Nurse #78 walked out of a resident room and approached the medication cart. She indicated she did not know the cart had been left unlocked. Respiratory Therapy Nurse #78 indicated the facility was supposed to be getting a new medication cart because that one did not always lock. The medications in the cart included, but were not limited to, the following: three boxes of Budesonide (steroid and decongestant), ten boxes of Albuterol Sulfate (bronchodilator) 2.5 mg/ 3 ml vials, and 29 boxes of Duoneb (bronchodilator). Respiratory Therapy Nurse #78 indicated there were approximately 30 vials of medication in each box.	F 0431	There were no residents affected by this alleged deficientpractice but all residents have the potential to be affected. The medication cart in question has beenfixed and now remains locked when unattended. The nurses and QMAs have been re-educated on keepingmedication and treatment carts locked when unattended with a special focus onplacing a cart out of service if the cart is unable to remain locked whenunattended. A monitoring tool has beenimplemented. The DON or designee will be responsible for checking the allmedication and treatment carts to ensure they remain locked when unattended andcompleting the monitoring tool. Thesechecks will be completed on scheduled work days as follows: Daily for two weeks, then weeklythereafter. Should a concern be found,immediate corrective action will occur. Results of these reviews and any corrective actions will be discussedduring the facility's monthly QA meetings on an ongoing basis for a minimum of6 months and the plan adjusted if indicated.	04/22/2016

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	During an interview with the DON (Director of Nursing) on 4/11/2016 at 2:23 p.m., she indicated she had requested two times to have that particular cart replaced. She further indicated the staff at the facility knew the medication cart did not lock regularly and that sometimes it "popped open" after a nurse had gone into a resident's room. She also indicated 10 cognitively impaired residents lived on the 200 hall. A "Facility Equipment Replacement Request" form was provided by the DON on 4/12/2016 at 8:42 a.m. The form indicated the facility had requested a medication cart and the detailed description of the problem was "outside lock will not stay locked." The form was signed by the DON and dated 2/28/2016. A policy titled "STORING DRUGS", dated 11/22/15 and provided by the DON on 4/12/2016 at 8:39 a.m., indicated the following: "...Policy: Drugs and biological will be stored in a safe, secure, and orderly manner at appropriate temperatures and accessible only to licensed nursing and pharmacy personnel or staff members lawfully authorized to administer medications...			

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	...2. When a permitted person is not in a drug storage area, the drug storage areas and devices must be kept locked...." 3.1-25(m)			
F 0492 SS=D Bldg. 00	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. Based on observation, interview, and record review, the facility failed to ensure an assessment was completed by a licensed nurse prior to the administration of an as needed medication by a Qualified Medication Aide (QMA) for 1 of 25 medication administration observations. (Resident #15) Findings include: During a medication administration observation, beginning on 4/12/16 at 1:20 p.m., QMA #3 administered a PRN (as needed) Tylenol #3 (a narcotic analgesic) tablet to Resident #15 for right lower extremity pain. QMA #3 did not obtain	F 0492	Resident #15 did not experience any negative outcomesrelated to this alleged deficient practice and is being assessed by a nurseprior to receiving a PRN pain medication. QMA #3 was immediately re-educated on not giving PRN pain medication until the resident is assessed by thenurse. All residents receiving PRN pain medications have thepotential to be affected. All are beingassessed by a nurse prior to receiving a PRN pain medication. The nurses and QMAs have been re-educated on not giving aPRN pain medication until the resident is assessed by the nurse. A monitoring tool has been implemented. The DON or designee will be responsible to	04/22/2016

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	authorization from a licensed nurse prior to administering the medication. QMA #3 indicated, at the time of the medication observation, she did not obtain authorization prior to administering PRN (as needed) medication(s), but would inform the nurse afterwards so they could assess for the effectiveness of the medication(s). On 4/12/16 at 1:33 p.m., the DON indicated QMA #3 was aware of the need to obtain approval from a licensed nurse prior to administering a PRN medication. Review of a policy titled, "PRN Medication Flow Sheet", dated 10/2014 and provided by the DON on 4/12/16 at 1:33 p.m., indicated the following: "...5. Should a QMA be assigned resident care, the QMA must obtain approval of the licensed nurse prior to administering the PRN medication. The licensed nurse must initial approval of the administration in the appropriate box...." 3.1-13(r)(2)		observemedication passes completed by QMAs on alternate shifts to ensure a nurseassesses pain prior to the QMA administering a pain medication. These observations will be completed onalternate shifts on scheduled work days as follows: Daily for two weeks, weekly for two weeks,monthly for two months, then quarterly thereafter. Should a concern be found, immediatecorrective action will occur. Results ofthese observations and any corrective actions will be discussed during thefacility's monthly QA meetings on an ongoing basis for aminimum of 6 months and the plan adjusted if indicated.	