

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/05/2014
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NAME OF PROVIDER OR SUPPLIER BRANDENBURG NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An Abbreviated Survey was initiated on 02/03/14 and concluded on 02/05/14 to investigate complaint KY21272. The Division of Health Care substantiated the allegation and identified actual harm with deficiencies cited at a Scope and Severity of a "G" at 42 CFR 483.20 Resident Assessment, 42 CFR 483.25 Quality of Care, and 42 CFR 483.60 Pharmacy Services. On 12/30/13, Resident #1 experienced untreated pain for Stage IV Lung Cancer with Metastasis to the Femur for eight (8) hours. The resident grimaced and moaned with movement and expressed to the family that the pain was "getting rough". The facility failed to notify the physician of available pain medications in the Emergency Drug Kit (EDK) box when the resident's pain medication had been exhausted and the pharmacy failed to refill the order with the thirty (30) pills that were due to the resident from a previous prescription. The resident was admitted to the care of Hospice on 12/31/13 and expired on 01/02/14.	F 000		
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's Care Plan and Pain Management policy, it was determined the facility failed to assure staff developed an initial care plan when the assessment triggered for such for	F 281		

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Betsy Appleby</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3-15-14</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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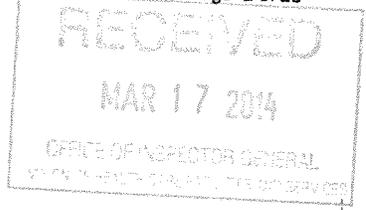
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F 281	<p>Continued From page 1</p> <p>one (1) of four (4) sampled residents, (Resident #1). The facility staff failed to develop an initial plan of care, prior to the completion of the first comprehensive assessment, to address Resident #1's Stage IV Cancer with Metastasis to the Femur, the resident's potential and actual pain, assessments of that pain, and evaluation of any pain medication and its effectiveness. Resident #1 experienced untreated pain for eight (8) hours, grimacing and moaning with movement and expressing to the family the pain was getting rough which resulted in actual harm. (Refer to F309 and F425.)</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding the development of the initial care plan. Review of the facility's Care Plan Policy Statement, not dated, revealed an individual's comprehensive care plan included measurable objectives and timetables for each resident. Any licensed nurse and or interdisciplinary team member could update the care plan to reflect changes. The care plan identifies the highest level of functioning the resident may be expected to attain based on assessments. The care plan is to incorporate risk factors, strengths, and expressed wishes regarding care and treatment goals.</p> <p>Review of the facility's policy regarding Pain Management Process, dated March 2011, revealed all residents have the right to be free of pain. Upon admission, the Pain Assessment form is used to collect data of the current presence of pain, type of pain scale to utilize, predisposing causes of the pain, location and etiology of the pain, quality, intensity and duration of the pain,</p>	F 281	<ol style="list-style-type: none"> 1. Resident #1 discharged from the facility on on 1/2/14. 2. A complete audit of all current resident's care plans was completed by the Director of Nursing and the MDS Nurse on 2-21-14 to ensure that all care plans have been completed and that appropriate care plans are in place to meet the needs of the resident. Any needed care plans were developed. 3. The Director of Nursing will re- educate all licensed nurses on the admission assessment and triggered care plans by 3-14-14. A written test will be given to all licensed personnel upon completion of the training and additional training will be provided as needed. No licensed staff will work after 3-14-14 without having received this re- education. 	3-20-14
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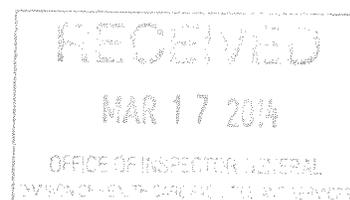
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F 281	Continued From page 2 accompanying symptoms associated with the pain, current management, pharmacological and non-pharmacological treatments, history of resolved and unresolved pain and the resident's pain management goal. The resident's care plan would be generated from the data collected from the pain assessment and updated upon any changes made to the resident's pain management regime or resident goals. The physician and family will be notified when pain levels are outside normal levels for each individual resident. The Situation, Background, Assessment, Recommendation (SBAR) form and other Interact II tools can be used to direct appropriate assessment, intervention and documentation related to the pain. Documentation of pain intensity will be recorded along with interventions for pain reduction using appropriate facility forms and no less than the Pain Assessment, Pain Flow Sheet, SBAR for notification and 24 hr Report for any pending re-evaluations or pending interventions. Post intensity evaluation would be assessed and documented in a timely manner. Upon follow-up, if the interventions were effective, process should be repeated until resident indicates adequate relief. When PRN pain meds are given regularly or frequently, the nurse must call the physician to obtain an updated order to meet the current pain needs of the resident. If the physician does not change the medication orders and the nurse believes the resident is at risk for continued pain, the Nursing Supervisor must be notified immediately. Residents who have received PRN pain medication more than twice in the last week or having a pain scale greater than seven (7) will be reviewed weekly by the Pain Management Committee. This will comply with the Inter-Disciplinary Team (IDT) approach to pain	F 281	4. The Director of Nursing or Charge nurse will audit five (5) resident records per week for twelve (12) weeks to ensure that care plans have been developed appropriately to meet the needs of the resident. The results of these audits will be reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing, MDS Coordinator, Maintenance Director, Dietary Services Manager and Activity Director on a monthly basis for three(3) months and will continue on a monthly basis until the team concludes the issue is resolved. The Medical Director will attend these meetings at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.	



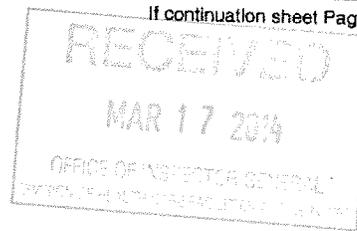
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F 281	<p>Continued From page 3</p> <p>management for each individual resident. When tracking of pain management is done weekly the care plan must be kept up to date. All care plan changes must be current in order to provide the latest information to caregivers. Pain scale assessments should be documented.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 12/12/13 with diagnoses of Stage IV Lung Cancer with Metastasis to the Femur, Left Inguinal Hernia, Trigeminal Neuralgia, Gout and Dementia. Review of Resident #1's physician orders, revealed the physician ordered Oxycodone (narcotic pain medication) 5 mg (milligram) one (1) tab by mouth every four (4) hours as needed for pain. Review of Resident #1's Admission Assessment, dated 12/12/13, revealed Resident #1 was not on a routine pain management program, but did receive as needed (PRN) medication and also received non-medication interventions for pain. However, the assessment did not specify the interventions. The Admission assessment stated if any of the preceding questions were answered with a yes response, proceed to and complete the Comprehensive Pain Assessment and Pain Care Plan.</p> <p>Interview with the MDS Coordinator, on 02/05/14 at 1:40 PM, revealed all the care plans developed for Resident #1 were provided for review. Review of the Initial Care Plans, provided by the facility and confirmed as complete by the Minimum Data Set (MDS) Coordinator, revealed no pain care plan was initiated prior to 12/30/13. Resident #1 began Hospice services on 12/31/13 and expired on 01/02/14.</p>	F 281		



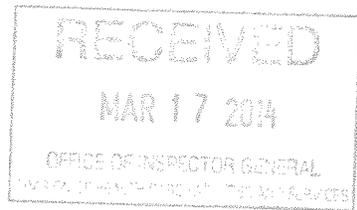
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F 281	<p>Continued From page 4</p> <p>Interview with Resident #1's family member, on 02/03/14 at 10:45 AM, revealed Resident #1 had Stage IV Lung Cancer and his/her pain was getting worse. The family member stated they had to ask for the pain medication because the medication was ordered as needed.</p> <p>Review of the PRN (as needed) Flow Sheet, identified by the facility as the only one they had, was blank. Review of the 24 Hour Report, under unusual behaviors listed Resident #1's condition as "... no change". Review of the controlled substance record for December 2013 revealed the resident received Oxycodone twice on 12/17; three times on 12/18; twice on 12/19 and 12/24; three times on 12/25 and 12/26; five times on 12/27; twice on 12/28 and 12/29; and, once on the other days.</p> <p>Review of Resident #1's Medication Administration Record (MAR), revealed Resident #1 received the last available dose of Oxycodone 5 mg, on 12/30/13 at 8:00 AM. Further review of the MAR for Resident #1 during the month of December 2013, revealed an order for Tylenol 650 mg po every 4 hours as needed for pain/fever. The MAR was blank indicating no medication was provided to the resident although the medication was available for use.</p> <p>Further interview with the family member, on 02/03/14 at 10:45 AM, revealed the resident could have had additional pain medication at 12:00 PM and 4:00 PM. At 1:00 PM, the family stated they asked the nurse for pain medication, and again at 7:00 PM they asked the nurse about the medication. The nurse informed the family that the prescription had to be faxed to the pharmacy, and that was when another nurse informed the</p>	F 281		



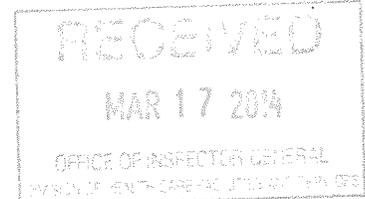
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F 281	<p>Continued From page 5</p> <p>family, they could go to their Pharmacy to get the medication filled faster.</p> <p>Review of the MAR revealed Resident #1 received his/her next dose of pain medication at 8:30 PM after the family came back from the pharmacy.</p> <p>Interview with the family's pharmacy, on 02/05/14 at 2:45 PM, revealed the prescription was brought in at 7:00 PM and filled by 7:27 PM.</p> <p>Review of the care plans, revealed a pain care plan was initiated on 01/01/14, two days after the resident had to wait eight (8) hours for pain medication. The care plan stated Resident #1 was at risk for alteration in comfort. The pain care plan revealed the approaches were to utilize the pain assessment, identify the location and rate of pain prior to and after any interventions. The staff was to attempt to document the effectiveness of non-pharmacological interventions as appropriate, and report unrelieved or unacceptable levels of pain to the Medical Doctor (MD) as needed.</p> <p>Review of Resident #1's PRN (as needed) Flow sheet for Analgesics and Other Medication, not dated, revealed the form was blank. On the form it outlined the problem, pre-treatment pain intensity, non-medication interventions, medications given, post treatment time, results of the treatment and post treatment intensity.</p> <p>Review of the PRN Flow sheet for Analgesics and Other Medication, not dated, revealed no documentation that the thirty (30) doses of Oxycodone 5 mg had been given.</p>	F 281		



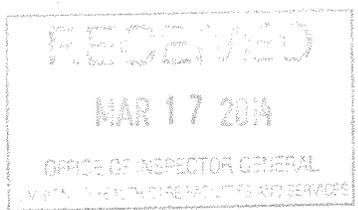
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F 281	<p>Continued From page 6</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 02/05/14 at 11:16 AM, revealed she did not know why she did not document in the Nursing Notes the care that was provided to Resident #1. LPN #3 stated she usually documented in the Nurses Notes and she was responsible to provide the care required by Resident #1. LPN #3 stated she was taught she could document in the Nurses Notes about pain medication provided or document on the PRN flow Sheet. However, she had completed neither.</p> <p>Review of Resident #1's Nurses Notes, dated 12/30/13, revealed no documentation of any interventions utilized between the hours of 12:00 PM and 8:30 PM, while Resident #1 was waiting for pain medications to arrive and experiencing pain.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 02/05/14 at 1:45 PM, revealed when there was a new admission the nursing staff was responsible to complete a nursing assessment, pain assessment and initiate a pain care plan if the resident triggered for pain. This plan would inform the nurses what was needed for the resident's care. LPN #6 stated nurses were able to initiate care plans and revise care plans.</p> <p>Interview with the MDS Coordinator, on 02/05/14 at 3:03 PM, revealed based on the care plan the resident's PRN Flow sheet for Analgesics should have been filled out by the nursing staff. The MDS Coordinator stated when she completed her assessments she looked at the MAR and the Nurses Notes. She did not look at the PRN Flow sheet because the form was not appropriately filled out. The MDS Coordinator stated she had</p>	F 281		



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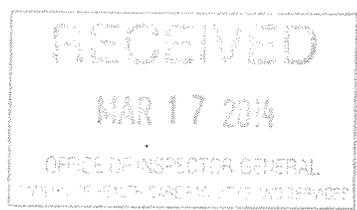
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F 281	Continued From page 7 not informed anyone about the form not being completed. The MDS Coordinator stated any nursing staff could update or initiate a care plan. Interview with the Director of Nursing (DON), on 02/05/14 at 3:13 PM, revealed she expected the nursing staff to document on the PRN Flow Sheet for Analgesics. The DON stated through review of the Nurses Notes the nurses were not documenting the effectiveness of the medication, pain levels or other interventions. The DON stated if the nurses utilized the PRN flow sheet they would be following the care plan. The DON stated nurses could initiate and revise care plans.	F309	<ol style="list-style-type: none"> Resident #1 was discharged on 1/2/14 Pain assessments have been completed on all current residents by Licensed Staff and reviewed by the Director of Nursing to ensure that interventions are meeting the pain needs of the residents. The assessments were completed by 2-21-16. Any resident identified as not having their pain needs met, will have physician notification by charge nurse for further direction. All resident's medications have been audited by Director of Nursing or RN Charge Nurse to ensure that they are available and if unavailable, the resident's physician has been notified. This was completed by 03-13-14. All licensed nurses will be re-educated by the Director of Nursing or RN Charge Nurse on 3-19-14 on the pain management program to include completion of assessments when triggered on admission, initiation of care plans, medications and 	3-20-14
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #1) was free from pain. The facility failed to administer pain medication to Resident #1 when requested, failed to ensure the medication had been reordered timely, failed to notify the Medical Doctor of available medications in the Emergency Drug Kit (EDK) box that could			



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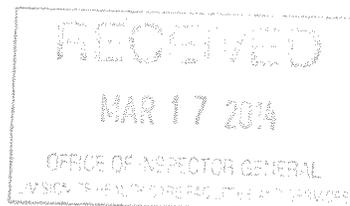
F 309 Continued From page 8
have been utilized until the pain medication was delivered, resulting in Resident #1 experiencing continued pain for eight (8) hours from Stage IV Lung Cancer with Metastasis to the Femur. Hospice accepted the resident on 12/31/13 and the resident expired 01/02/14. (Refer to F425)

The findings include:

Review of the facility's policy regarding Pain Management Process, dated March 2011, revealed all residents have the right to be free of pain. Upon admission, the Pain Assessment form is to collect data of the current presence of pain, type of pain scale to utilize, predisposing causes of the pain, location and etiology of the pain, quality, intensity and duration of the pain, accompanying symptoms associated with the pain, current management, pharmacological and non-pharmacological treatments, history of resolved and unresolved pain and the resident's pain management goal. The resident's care plan will be generated from the data collected from the pain assessment and updated upon any changes made to the resident's pain regime or resident goals. The physician and family will be notified when pain levels are outside normal levels for each individual resident. The SBAR and other Interact II tools can be used to direct appropriate assessment, intervention and documentation related to the pain. Documentation of pain intensity will be recorded along with interventions for pain reduction using appropriate facility forms and no less than the Pain assessment, Pain flow sheet, SBAR for notification and 24 hour report for any pending re-evaluations or pending interventions. Post intensity evaluation would be assessed and documented in a timely manner. Upon follow-up, if the interventions were effective,

F 309 interventions to meet the pain needs of the resident, and assessment/notification of the physician including use of the SBAR/Interact process. Training also included notification to resident's physician of the Narcotic Emergency Drug Kit (NEDK) if medication is not available so that the physician may order a pain medication from the (NEDK) and notification of the physician if the medication is not available. The Night Shift nurses have been educated by Director of Nursing or RN Charge Nurse by 03-19-14 to compare refill sheet to delivery receipts and return to Director of Nursing nightly.

4. The Director of Nursing or RN Charge nurse will audit five(5) residents per week for twelve (12) weeks to ensure that pain meds are available and that the Physician has been notified of NEDK if appropriate. The Director of Nursing or RN Charge Nurse will audit all refill requests and delivery receipts three(3) times per week to ensure medications are refilled timely.



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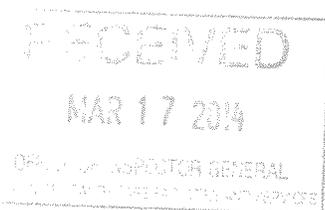
F 309 Continued From page 9
the process should be repeated until resident indicates adequate relief. When PRN pain meds are given regularly or frequently, the nurse must call the physician to obtain an updated order to meet the current pain needs of the resident. If the physician does not change the medication orders and the nurse believes the resident is at risk for continued pain, the Nursing Supervisor must be notified immediately. Residents who have received PRN pain medication more than twice in the last week or having a pain scale greater than seven (7) will be reviewed weekly by the Pain Management Committee. This will comply with the IDT approach to pain management for each individual resident. When tracking of pain management is done weekly the care plan must be kept up to date. All care plan changes must be current in order to provide the latest information to caregivers. Pain scale assessments should be documented.

Review of the facility's policy regarding New Orders for Schedule II Controlled Substances, revised 01/01/13, if the controlled substance is needed before the pharmacy can make arrangements for a timely delivery, the facility must fax a request to remove a controlled substance from the emergency drug supply to the pharmacy.

Interview with LPN #6, on 02/05/14 at 1:45 PM, revealed when there was a new admission the nursing staff was responsible to complete a nursing assessment, pain assessment and initiate a pain care plan if the resident triggered for pain.

Review of Resident #1's clinical record revealed the facility admitted the resident on 12/12/13 with

F 309 The results of these audits will be reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing, MDS Coordinator, Maintenance Director, Dietary Services Manager and Activity Director on a monthly basis for three(3) months and will continue on a monthly basis until the team concludes the issue is resolved. The Medical Director will attend these meetings at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.



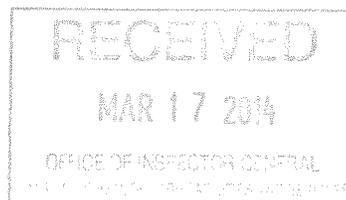
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F 309	<p>Continued From page 10</p> <p>diagnoses of Stage IV Lung Cancer with Metastasis to the Femur, Left Inguinal Hernia, Trigeminal Neuralgia, Gout and Dementia. Review of Resident #1's Admission assessment, dated 12/12/13, revealed Resident #1 was not on a routine pain management program, but did receive as needed (PRN) medication and also received non-medication interventions for pain. However, this assessment did not describe the interventions to be used. The Admission assessment stated if any of the preceding questions were answered with a "yes" response (as noted above the resident received a PRN pain medication) then proceed to and complete the Comprehensive Pain Assessment and Pain Care Plan. Review of the Comprehensive Pain Assessment, dated 12/12/13, revealed it was an admission assessment and Resident #1 was free of pain. The assessment also stated Resident #1 denied any history of pain. Review of Resident #1's initial Care Plan, revealed there was no initial pain care plan provided. Review of Resident #1's Physician Orders, dated 12/12/14, revealed the physician ordered Oxycodone (a controlled narcotic) 5 mg one (1) tab by mouth every four (4) hours as needed for pain.</p> <p>Interview with Resident #1's family member, on 02/03/14 at 10:45 AM, revealed Resident #1 had Stage IV Lung Cancer with metastasis to the Femur and his/her pain was getting worse. The family member stated they had to ask for pain medication because the medication was ordered as needed.</p> <p>Review of Resident #1's Medication Administration Record, revealed the staff administered Resident #1 the last available dose of Oxycodone 5 mg, on 12/30/13 at 8:00 AM.</p>	F 309		



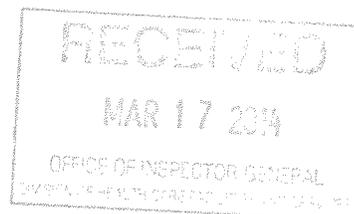
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F 309	<p>Continued From page 11</p> <p>However, the resident had an order for Tylenol 650 mg po every 4 hours as needed for pain/fever. Review of the MAR revealed no documented evidence the resident was provided this medication.</p> <p>Further interview with Resident #1's family member, on 02/03/14 at 10:45 AM, revealed the resident whispered into the family member's ear that the "pain was getting rough", at 1:00 PM they asked the nurse for additional pain medication and the nurse stated there was no pain medication left and they would have to order the medication. The family member stated the resident was yelling out in pain, and at 7:00 PM they asked the nurse again about the medication. The nurse stated they had a prescription, but no drug. The nurse informed the family that the prescription had to be faxed to Indianapolis and that was when another nurse told the family they could go to their pharmacy to get the medication filled faster.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 02/05/14 at 8:47 AM, revealed when the resident was repositioned he/she would grimace, the resident was very stiff and movement hurt him/her.</p> <p>Interview with CNA #3, on 02/05/14 at 11:05 AM, revealed every time she went into the room she would ask if the resident needed to be repositioned. When they moved the resident he/she would twitch his/her arms and torso.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 02/04/14 at 3:54 PM, revealed she could not remember much, but did remember giving the last dose of pain medication to Resident #1. LPN</p>	F 309		



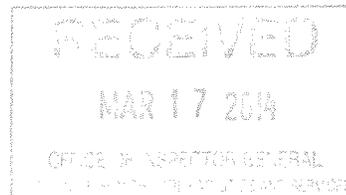
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F 309	<p>Continued From page 12</p> <p>#2 stated that looking at the MAR for December 2013, she could see how Resident #1 did not receive pain medication consistently every four hours. LPN #2 stated normally when a drug ran low she would pull the sticker and place the sticker on a medication refill sheet which would then be faxed to the pharmacy. LPN #2 stated that once a medication sticker was pulled from the card, the pharmacy would usually deliver the medication that night. LPN #2 could not remember if the sticker was already pulled when she gave the last dose. LPN #2 stated she did not remember Resident #1 grimacing, crying or appearing restless.</p> <p>Review of a Refill Reorder Form, dated 12/28/13, revealed Resident #1's Oxycodone 5 mg had been reordered to be filled on that date.</p> <p>Interview with LPN #3, on 02/04/14 at 4:34 PM, revealed when she came on her shift at 2:00 PM on 12/30/13, while doing her narcotic count with LPN #2, LPN #2 stated she gave Resident #1 his/her last pain medication. Resident #1's family approached the nurse and was concerned about Resident #1's pain medication because the resident had not received it yet. LPN #2 stated she took Resident #1's vitals and he/she was moaning. She stated Resident #1's oxygenation was between 86% and 88%. LPN #2 stated in report she was told Resident #1 was fine, but she could see Resident #1 was not fine based on the oxygen level and blood pressure. LPN #2 stated to LPN #3 that LPN #1 had completed a Situation, Background, Assessment, Recommendation (SBAR) form for her about Resident #1's oxygen levels, but not his/her pain.</p> <p>Continued interview with LPN #2, on 02/05/14 at</p>	F 309		



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F 309	<p>Continued From page 13</p> <p>10:07 AM revealed she did not remember the family coming to her and LPN #3 during the narcotic count to inform them of Resident #1's pain. LPN #2 stated she did not remember completing a SBAR on Resident #1's oxygen saturation though it was in her hand writing; however, it was not signed.</p> <p>Review of the Interact SBAR, no date provided, revealed Resident #1's blood pressure was 67/42 and oxygen saturation of 89%.</p> <p>Continued interview with LPN #3, on 02/04/14, revealed she then called the Doctor who said she would have to look up what she could order for Resident #1 because the resident was having difficulty swallowing. LPN #3 stated she was a new nurse as of October 2013 and LPN #6 helped her with ordering the pain medication. LPN #3 stated Medical Records then went to retrieve the first prescription from the Doctor's office.</p> <p>Interview with LPN #6, on 02/05/14 at 1:45 PM, revealed LPN #3 came to her around 3:00 PM or 4:00 PM to ask for assistance with Resident #1's medication.</p> <p>Interview with Medical Records, on 02/05/14 at 9:08 AM, revealed she remembered obtaining a prescription from the Doctor's office. Medical Records stated she remembered it was after dinner when she was asked to go pick up the prescription.</p> <p>Further interview with LPN #3, on 02/04/14 at 4:34 PM, revealed the pharmacy called about two (2) hours later (5:00 PM) and stated the Doctor did not state the route in which the medication</p>	F 309		
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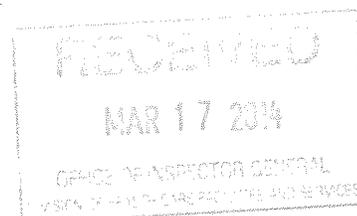
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F 309	<p>Continued From page 14 was to be given.</p> <p>Interview with the Doctor, on 02/05/14 at 9:45 AM, revealed she remembered there were two (2) prescriptions that were written. The first prescription had to be rewritten because there was no route identified.</p> <p>Further interview with LPN #3, on 02/04/14, revealed she then asked LPN #6 about the Emergency Drug Kit (EDK) box, but LPN #6 stated they needed a hard script to get into the box. LPN #2 stated she was not sure if this was right or wrong and she was not familiar with the process.</p> <p>Interview with LPN #6, on 02/05/14 at 1:45 PM, revealed she was the veteran nurse in the situation and did not know why she did not suggest the EDK box. LPN #6 stated she did not inform the Director of Nursing because she thought she could handle the situation. LPN #6 stated when the second prescription came in most of the Administrative staff was gone for the evening.</p> <p>Interview with the Doctor, on 02/05/14 at 10:39 AM, revealed she remembered there was a problem with the prescription, her assistant then took the second prescription to the facility by 6:00 PM because her office was closing.</p> <p>Further interview with LPN #6, on 02/05/14 at 1:45 PM, revealed the Doctor's office closed at 6:00 PM, so the Doctor's assistant came to the facility with the new prescription. LPN #6 stated she took the prescription and called the pharmacy and told them she was going to fax it to them. In the mean time the family member came to her</p>	F 309		



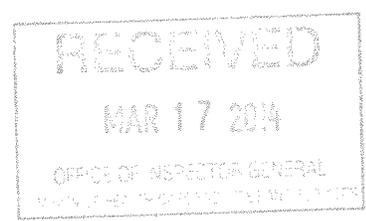
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F 309	<p>Continued From page 15</p> <p>crying and saying when would they give Resident #1 his/her medication. LPN #6 stated then a family member came up and stated, "give me the damn prescription and I will get it filled myself". So the facility staff gave the family member the prescription and the nurse called the facility's pharmacy and told them to forget the order, that the family was taking the prescription to another pharmacy. LPN #6 stated the family's pharmacy called and stated they could not fill the second prescription so LPN #6 then called the Doctor back. LPN #6 stated the Doctor asked the family's pharmacy what they had and wrote a prescription for that medication. Resident #1 was having a difficult time swallowing, eating and refusing to have anything placed into his/her mouth; Mophine Sulfate was ordered to help with swallowing.</p> <p>Interview with LPN #3, on 02/05/14 at 11:16 AM, revealed she did not know why she did not document in the Nursing Notes the care that was provided to Resident #1. LPN #3 stated she usually documented in the Nurses Notes and she was responsible to provide the care required. LPN #3 stated she was taught she could document in the Nurses Notes about pain medication provided or document on the PRN flow sheet.</p> <p>Interview with the MD, on 02/05/14 at 9:45 AM, revealed she got a call that the resident was in horrific pain and she called and talked with the family's pharmacy. The family member brought the medication back to the facility to ensure the resident got it quickly. There were several hours in delay. The delay in the system was the pharmacy. She further stated the facility did not call her prior to the medication running out and</p>	F 309		



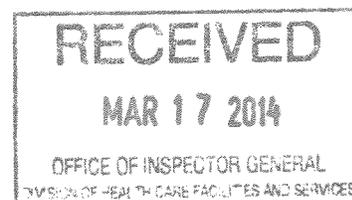
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F 309	<p>Continued From page 16</p> <p>the last dose given. She stated she knows they did not do well with Resident #1. The MD further stated she did not want this to happen again, so she went to the pharmacy herself and obtained medication for another resident who was also dying.</p> <p>Interview with the Director of Nursing (DON), on 02/05/14 at 3:13 PM, revealed there were no other PRN flowsheets for Resident #1 only the one provided for review. However, this form was blank and only contained the last name of the resident. She further stated she worked the Monday of 12/30/13 and did not remember any of the nursing staff coming to her to inform her they were having problems with obtaining a pain medication. The DON stated she did not hear of any complaints from family members as well. The DON stated she had written a note to herself on 12/31/13 wanting to know what happened in regards to Resident #1's medication. The DON stated she informed the nurses if they were having problems with obtaining pain medication they needed to request a hard script so that they could obtain medication from the EDK box, while waiting for pharmacy to bring in pain medications.</p> <p>Review of the medication in the EDK box, revealed five (5) medications which included four (4) were by mouth, one (1) was a patch and one (1) was an injection. The EDK box contained six (6) each of Hydrocodone/Apap 5/325g tab, Fentanyl 25 mcg/hr patch, and Morphine 10 mg/ml injection. However, none had been removed to administer to Resident #1.</p> <p>Further interview with the DON, on 02/05/14 at 3:13 PM, revealed she would expect the nursing staff to lock and see what type of drugs were</p>	F 309		



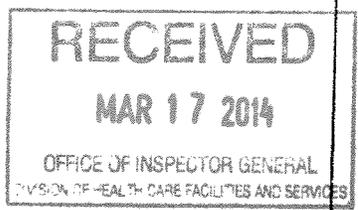
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F 309	<p>Continued From page 17</p> <p>available in the EDK box. The DON stated when a nurse administered a pain medication they were expected to document the pain levels and effectiveness. The DON stated the nurses should document the non-pharmacological interventions and also document correspondence with the pharmacist. If the nurses were having some problems she would also expect them to document on the 24 Hour Report, nurse to nurse, shift to shift report. The DON stated depending on the type of cancer, it could be painful. She stated she felt the process failed because of the lack of communication with nursing. The DON stated it was not the family's responsibility to obtain pain medication for the resident.</p> <p>Review of the 24 Hour Report revealed no documentation about Resident #1's pain medication not being available nor the pain experienced by the resident.</p> <p>Interview with the Administrator, on 02/05/13 at 4:40 PM, revealed when she left for the evening of December 30th, she over heard the family talking to the nurse. The Administrator stated she heard the nurse inform the family, the doctor was sending another prescription so they could get a stat order. She further stated the nursing staff did not tell her how long the resident had been without pain medication. The Administrator stated a resident should not go without pain medication for eight (8) hours and they should have made an effort to ensure the resident was free of pain. In addition, the Administrator stated she would expect the nursing staff to inform her or the DON if they were having problems and it was her impression the nursing staff had it under control. The Administrator further stated she would expect the nursing staff to try to obtain medications from</p>	F 309		



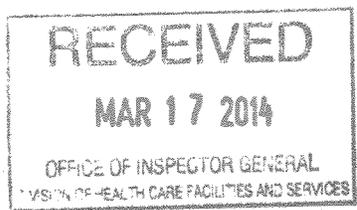
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F 309	Continued From page 18 the EDK box. She stated the breakdown was that the nurses did not provide Resident #1 with pain medication that was needed, nor inform the DON to ensure the resident received his/her pain medication.	F 309		
F 425 SS=G	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to ensure pharmaceutical services were provided for the dispensing of as needed (PRN) pain medications for one (1) of four (4) sampled residents (Resident #1). The facility failed to</p>	F 425	<ol style="list-style-type: none"> 1. Resident #1 discharged on 1/2/14. 2. The Director of Nursing or RN Charge Nurse has audited all resident's medication orders to medications available to ensure that all have been refilled and are available and has notified the resident's physician if they are not available. This was completed on 03-11-2014. 3. All Night Shift licensed nurses were re-educated by the Director of Nursing or RN Charge Nurse by 03-19-2014 regarding the new process of night shift being required to validate medication refill sheet to delivery sheet. The Medical Director has approved this process. The Night Shift Nurse will check the delivery receipt to the refill request sheet to verify all request for refills have been filled. This will be turned in to the Director of 	3-20-14



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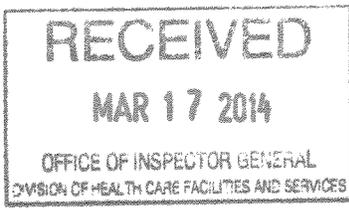
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F 425	<p>Continued From page 19</p> <p>ensure the pharmacy refilled orders and sent them to the facility timely to avoid interruption of medication availability. Resident #1 had to wait eight (8) hours for pain medication to be administered; he/she displayed grimacing and moaning with movement. Resident #1 stated to his/her family the pain was getting rough. Hospice accepted the resident on 12/31/13 and the resident expired on 01/02/14.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Providing Pharmacy Products and Services, revised 01/01/13, revealed the staff should remind the prescriber (MD) that a delay in medication therapy can be prevented by using a medication that is included in the facility's emergency medication supply as permitted by State regulations. If a medication was considered essential and could not be substituted or delayed, contact the emergency number provided by Pharmacy.</p> <p>Review of the facility's policy regarding New Orders for Schedule II Controlled Substances, revised 01/01/13, revealed new orders for Scheduled II controlled substances require a complete written prescription prior to dispensing, unless there is an emergency situation. Facility staff may fax Schedule II prescriptions for long term care residents and terminally ill residents. The prescriber should provide pharmacy with verbal authorization for Schedule II controlled substances in cases of emergency as determined by: immediate administration of the Schedule II controlled substance is necessary for proper treatment of the intended ultimate user; there is</p>	F 425	<p>Nursing. All Night Shift Nurses will receive a post test to validate competency of education. No night shift Nurse will work after 3-19-14 without having this re-education. A representative from the Pharmacy, Director of Nursing or RN Charge Nurse will re-educate all licensed nurses on 3-13-14 regarding refill requests and pharmacy procedures. No licensed nurse will work after 3-19-14 without having received this re-education. In addition, the QA committee met on 3-13-14 and reviewed the pharmacy policy and procedure related to filling and refilling of medications and discussed with the General Manager of the pharmacy as well as pharmacy QA regarding the concern and noted the following. The pharmacy reviewed the concerns with medication delivery times and has now opened the Louisville operation for 24 hour service instead of service routed to Indianapolis IN, for improved service times. The QA committee felt that these changes as well as the emphasis</p>	
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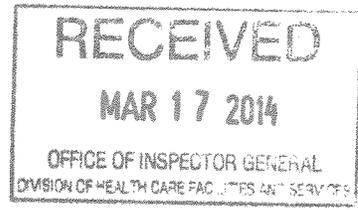
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/05/2014
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F 425	<p>Continued From page 20 . no appropriate alternative treatment available; and it is not reasonable for the prescriber to provide a written prescription to be presented to the person dispensing the Schedule II substance prior to dispensing. If the controlled substance is needed before the pharmacy can make arrangements for timely delivery, the facility must fax a request to remove a controlled substance from the emergency drug supply to the pharmacy.</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 12/12/13 with diagnoses of Stage IV Lung Cancer with Metastasis to the Femur, Left Inguinal Hernia, Trigeminal Neuralgia, Gout and Dementia. Review of Resident #1's Physician Orders, revealed the physician ordered Oxycodone 5 (a controlled narcotic) mg one (1) tab by mouth every four (4) hours as needed for pain, quantity of sixty (60) to be dispensed.</p> <p>Interview with LPN #3, on 02/04/14 at 4:34 PM, revealed she looked at the resident and took his/her vital signs. The resident was moaning and his/her oxygen saturations were 86% to 88%. She stated she could see the resident was not "fine" as she was told in report.</p> <p>Interview with Resident #1's family member, on 02/03/14 at 10:45 AM, revealed the resident whispered into the family member's ear that the "pain was getting rough".</p> <p>Review of the Refill Reorder Form, dated 12/28/13, revealed Resident #1's Oxycodone 5 mg medication was re-ordered for the remaining thirty (30) tabs on that date.</p> <p>Interview with Registered Nurse (RN) #1, on</p>	F 425	<p>on Narcotic Emergency Drug Kits(NEDK) was sufficient to correct the identified concerns.</p> <p>4. The added process of the Night Shift Nurse validating refill request will continue to ensure ongoing monitor of the refill process. The Director of Nursing or RN Charge Nurse will audit all refills and delivery receipts 3 times per week for twelve (12) weeks. The results of these audits will be reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing, MDS Coordinator, Maintenance Director, Dietary Services Manager and Activity Director on a monthly basis for three (3) months and will continue on a monthly basis until the team concludes the issue is resolved. The Medical Director will attend these meetings at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.</p>	
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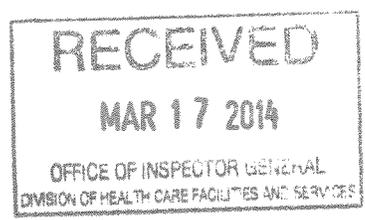
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F 425	<p>Continued From page 21</p> <p>02/04/14 at 4:17 PM, revealed the night shift mostly completed the medication audits. RN #1 stated he normally determined when a narcotic needed to be re-ordered by the fact the medication card comes in a pack of thirty (30). RN #1 stated when the medication got below the half way mark he would then re-order the narcotic medication. RN #1 stated he would then pull the sticker and place it in on a refill page and fax the information to the pharmacy.</p> <p>Review of Resident #1's Medication Administration Record, revealed the facility staff administered Resident #1 the last dose of Oxycodone 5 mg medication on 12/30/13 at 8:00 AM.</p> <p>Interview with Resident #1's family member, on 02/03/14 at 10:45 AM, revealed Resident #1 had Stage IV Lung Cancer with metastasis to the Femur and his/her pain was getting worse. On the 12/30/13, Resident #1 was given his/her last pain medication at 8:00 AM. The family asked the nurse for pain medication around 12:00 PM and the nurse stated there was no more pain medication left and they would have to order the medication. The family member stated at 7:00 PM they asked the nurse again where the medication was and the nurse stated they had a prescription, but no medication. The nurse informed the family that the prescription had to be faxed to the pharmacy and that was when another nurse informed the family they could go to their pharmacy and get the medication filled faster.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 02/05/14 at 10:44 AM, revealed their pharmacy was in Cincinnati, and there was a</p>	F 425			

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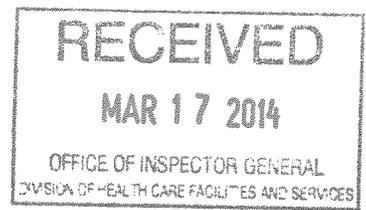
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F 425	<p>Continued From page 22</p> <p>branch in Louisville they used. She further stated the facility contracts through pharmacies in three (3) surrounding towns that were forty-five (45) minutes in each direction. She stated it takes pharmacy about two (2) hours if they need something STAT.</p> <p>Interview with LPN #2, on 02/04/14 at 3:54 PM, revealed normally when a drug ran low she would pull the sticker and place the sticker on a medication refill sheet which would then be faxed to pharmacy. LPN #2 stated that once a medication sticker was pulled from the card, the pharmacy would usually deliver the medication that night. LPN #2 could not remember if the sticker was already pulled when she gave the last dose.</p> <p>Interview with the facility's Consulting Pharmacist, on 02/05/13 at 2:24 PM, revealed the Oxycodone 5 mg was a schedule II drug and there was a quantity of thirty (30) tabs that could be refilled. The Consulting Pharmacist stated the pharmacy had received a re-order on 12/28/13. The re-order defaulted and alerted the technician. The technician should have checked the alert, but instead, checked it off as seen and did not refill the medication. The Consulting Pharmacist stated he did not know why the pharmacy did not refill the medication. However, the prescription was no longer active in the computer and the prescription looked like it had been discontinued. Basically the Technician checked it off, instead of refilling the drug.</p> <p>During further interview with the Consulting Pharmacist he stated the way the EDK box worked was the facility was required to fax the prescription to the pharmacy and then call the</p>	F 425			



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F 425	<p>Continued From page 23</p> <p>pharmacy to get access to the controlled stock. The pharmacy would give them a control number that they have to put on paper to sign out the drug. They have to have permission to verify there was an active prescription and the pharmacy gave the approval if the drug was in the EDK box.</p> <p>Interview with the family's pharmacy revealed the prescription was brought in at 7:00 PM and filled by 7:27 PM.</p> <p>Interview with the MD, on 02/05/14 at 9:45 AM, revealed she remembered there were two prescriptions written. The first one she was told that they did not have a route and she was told to re-write the second prescription. She then got a call that the resident was in horrific pain and she called and talked with the family's pharmacy. The family member brought the medication back to the facility to ensure the resident got it quickly. There were several hours in delay. The delay in the system was the pharmacy. She further stated the facility did not call her prior to the medication running out and that they had given the last dose. She stated she knew they did not do well with Resident #1. She stated she knew when the medication had to be switched from pill to liquid it was hard to obtain. The MD further stated she did not want this to happen again, so she went to the pharmacy herself and obtained medication for another resident who was also dying.</p> <p>Interview with the Administrator, on 02/05/14 at 4:40 PM, revealed it sounded like the facility had a break down with the pharmacy process in getting the pain medication needed for Resident #1. The Administrator further stated the turn around time for stat medications orders is four (4)</p>	F 425			



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F 425	Continued From page 24 to six (6) hours and they needed to talk to pharmacy about it.	F 425		

