

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/21/2014
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245	
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F 000	INITIAL COMMENTS	F 000		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 drug distribution systems in which the</p>	F 431 F431	<p>Oaklawn and PCA Pharmacy have strengthened the current system for all controlled substances to minimize loss or diversion, and to prevent misappropriation of residents' narcotic medications.</p> <p>On 5-13-14 Licensed Practical Nurse (LPN) #5 was arrested by Louisville Metro Police, for theft of a resident's "as needed" (PRN) medication. LPN #5 was immediately terminated from employment with Oaklawn. On 5-14-14 a complaint on LPN #5 was filed with the Kentucky Board of Nursing.</p> <p>On 5-13-14, the four residents, whose controlled drug records were suspicious for drug diversion by LPN #5, were assessed and interviewed by the Unit Manager for any signs and symptoms of pain to determine if pain control needs were being met.</p>	<p>6/20/14 6-21-14 Per B. Stephens by PB 6-6-14</p>

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

X M Burke Stephens

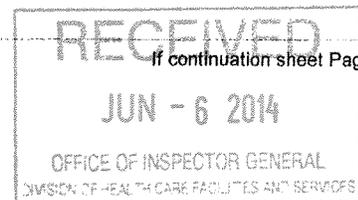
TITLE

X Administrator

(X6) DATE

X 6/6/14

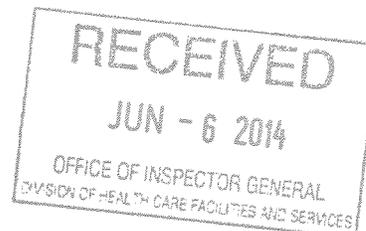
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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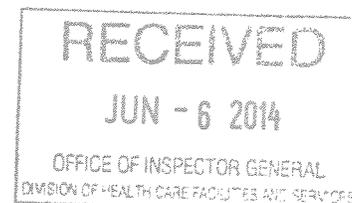
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F 431	<p>Continued From page 1 quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Abuse Policy and the Prevention of Narcotic Drug Diversion, it was determined the facility failed to have an effective system in place for all controlled substances to minimize loss or diversion, and to prevent misappropriation of residents' narcotic medications. Over an eight (8) month period, one (1) Licensed Practical Nurse signed out narcotics which may or may not have been administered to three (3) Residents of three (3) sampled residents, Residents #1, #2, and #3 and two (2) of two (2) Unsampled Residents, A and B, on one (1) of four (4) nursing units.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Abuse Prohibition Policy and Procedure, not dated, revealed the facility had a zero tolerance for any acts of abuse. The policy defined misappropriation of resident property as the deliberate misplacement, exploitation, wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</p> <p>Review of the facility's policy titled Prevention of Narcotic Drug Diversion, dated 03/01/14, revealed it was the facility's policy to maintain processes that would prevent and minimize the potential for drug diversion within the facility and</p>	F 431	<p>No signs, symptoms, or verbalizations of pain were identified by these four residents. On 5-20-14 all Nurses and Certified Medication Technicians (CMTs) were re-educated by either the Director of Nursing, Assistant Director of Nursing, or Director of Education on the importance of ensuring they are logged on and documentation is under their user name when in the AccuFlo system, and to change users or log off when not using the AccuFlo system. The E-MEDPASS Check-off form used in orientation with Nurses and CMTs was revised to include the above information.</p> <p>Identification of other residents potentially affected by same deficient practice:</p> <p>On 5-14-14, all residents currently in the facility were either interviewed or assessed by the Unit Manager or Nurse Supervisor to ensure pain control needs were being met. No pain control concerns were identified. On 5-14-14 there was also a review of all residents' controlled drug records currently in use in the facility by either the Unit Manager or Nurse Supervisor. There was no identification of any suspicious activity of narcotic diversion.</p>	



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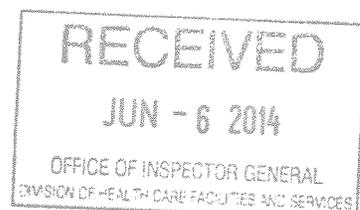
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F 431	<p>Continued From page 2</p> <p>ensure safe and proper handling of narcotic medications. Under the heading, Maintenance of the Narcotic Control Cart Count Process, each oncoming nurse and the nurse relinquishing responsibility of the cart would verify each narcotic by reviewing the resident's name, drug, dose, and the amount of the drug in the cart. Both nurses should be looking at both the drug and the narcotic count sheet. Any discrepancies in this count should immediately be reported to the Shift Supervisor, Assistant Director of Nursing (ADON), or the Director of Nursing (DON).</p> <p>Review of a document the facility provided titled, Read and Sign Nurse, Narcotic Count, not dated, revealed all narcotic cards were to be inspected for anything suspicious every shift change. Staff were to make sure there were not any taped backs, or missing pills out of place, and was to examine the last two administrations of narcotic on the paper Medication Administration Record (MAR) for anything suspicious. The document revealed the staff were to report any suspicion to the Unit Manager and Dana Erwin right away. A sign-in sheet accompanied this one page document with names of staff who reviewed the document.</p> <p>Review of a Facility Complaint Form, dated 05/14/14, provided by the DON revealed Licensed Practical Nurse (LPN) #5, was arrested at the facility on 05/13/14 at 12:50 PM, by Louisville Metro Police, for theft of a resident's narcotic medication. The statement on the complaint form revealed the facility cooperated with the Louisville Metro Police Department's Narcotic/Prescription (Rx) Squad in the investigation and the arrest of LPN #5. The facility also started its own internal investigation of LPN</p>	F 431	<p>To ensure the deficient practice does not reoccur:</p> <p>The Director of Nursing, Director of Education, Assistant Director of Nursing or House Supervisor will re-educate all Nurses by June 20, 2014, on maintaining processes to prevent narcotic drug diversion and misappropriation of residents' narcotic medications. This education will include the facility policy and procedure regarding Prevention of Narcotic Drug Diversion, as well as policies and procedures for logging off or changing users on medication carts.</p> <p>The education will also include the need to inspect narcotic cards and controlled drug records during each count, for any suspicious activity such as repetitive signatures or patterns of suspicious behavior. Further the education will include reporting any suspicions to the Director of Nursing and Administrator. All Nurses will be educated regarding the updated E-MEDPASS Check-off form, and it will be used to educate all Nurses and CMTs during orientation to the facility. The above will be completed by June 20, 2014 by the DON, ADON, and Director of Education.</p>		



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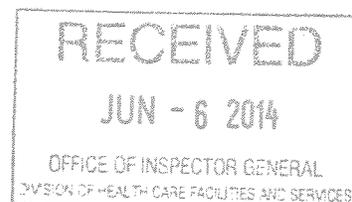
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F 431	<p>Continued From page 3</p> <p>#5's Narcotic sign-out activity, as discrepancies in medication administration patterns for Hydrocodone prescribed for five (5) residents had been noted. The medications in question were not administered to the residents on a routine basis, but were ordered on an as needed basis.</p> <p>Continued review of the investigation's summary revealed the facility identified areas of concern that included LPN #5 signing off as administering Narcotics prior to his/her scheduled start time, signing off as administering Narcotics sooner than ordered without calling the MD/ARNP, signing off as administering Narcotics under a Certified Medication Technician's (CMT's) log-in on the electronic Medication Administration Record (e-MAR), and not reporting the reason for the frequent Narcotic sign-outs to the Unit Manager (UM), to other nurses, or to the CMT. The frequent sign-outs were discovered to involve the Narcotic supply for Resident #1, Resident #2, Unsampled Resident A and Unsampled Resident B. The summary revealed 396 Narcotics were signed out, over an 8 month period by LPN #5, and were suspected as not being administered to the residents.</p> <p>Observation, on 05/19/14 at 1:10 PM, on initial tour of the English Oak Garden (EOG) unit did not reveal concerns with the unit's environment. Med carts were locked, and the patients' medical information was not directly visible. There were no observed concerns regarding staff to resident interactions.</p> <p>Observation, on 05/19/14 at 2:30 PM, of LPN #3 and CMT #7 during the shift change narcotic count revealed no concerns.</p>	F 431	<p>To monitor the above to ensure the solution is sustained:</p> <p>During the regular monthly visit by the contracted Pharmacist, he/she will check a random sample of five current residents' active Controlled Drug Records (CDRs) on each nursing unit for six months, and then this will be evaluated by QA Committee. The Pharmacist will check for appropriate dispensing of narcotic medications and any unusual or suspicious activity related to the reviewed group. The Pharmacist will notify the Director of Nursing and Administrator of any suspicions of misappropriation of residents' narcotic medications.</p> <p>The Administrator and Director of Nursing will continue to work with drug enforcement agencies on any suspected criminal activity.</p> <p>Bi-monthly, the Unit Managers will review 100% of current residents receiving narcotic medication for any questionable or diversionary activity, or patterns of suspicious dispensing by any Nurse or CMT.</p>		



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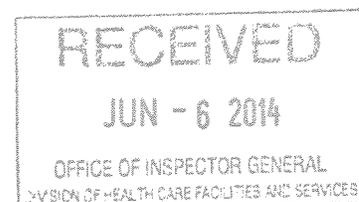
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F 431	<p>Continued From page 4</p> <p>Interview, on 05/19/14 at 2:35 PM, with LPN #3 revealed the nurse was supposed to sign out the controlled substance once the medication was administered to a resident, and this was to prevent a miscount, a miscommunication or any discrepancy about what was or was not administered. In addition, the nurse should evaluate and document the effect of the medication to determine if the resident experienced pain relief or the desired effect.</p> <p>1. Review of Resident #3's clinical record, revealed he/she was admitted to the facility 09/17/08 with diagnoses of a Personal History of Falls, Osteoarthritis, Generalized Muscle Weakness, and a history of Chest Pain. The resident had a care plan with interventions for his/her increased need for help with activities of daily living (ADLs), and a care plan for pain management.</p> <p>Observation, on 05/19/14 at 2:37 PM, revealed Resident #3 was seated in a wheelchair in his/her room, neatly dressed and waiting to be assisted by staff to a bingo activity.</p> <p>Interview, on 05/19/14 at 2:40 PM, with Resident #3 revealed he/she had lived at the facility for eleven (11) years. The resident stated that he/she did not need pain medication often, but did request it occasionally for pain related to a healing fracture of his/her right arm. Resident #3 stated the staff administered his/her meds when needed, and he/she thought the nursing staff administered the medications as the doctor had ordered them.</p> <p>2. Review of Resident #2's clinical record revealed he/she was admitted to the facility on</p>	F 431	<p>Bi-monthly, the Unit Managers will also perform a random check of all AccuFlo computers on the medication carts, to ensure the employee currently passing medications is the actual employee signed into the AccuFlo system. A random check of Nurses/CMTs on each unit will be interviewed to ensure understanding of the procedure for logging out of AccuFlo. The results of this surveillance will be reported to the Pharmacist who shall compile all surveillance results and submit a report to the quarterly QA committee until substantial compliance is achieved and maintained for one year.</p>		



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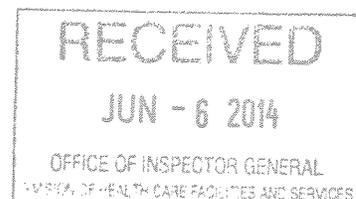
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F 431	<p>Continued From page 5</p> <p>11/25/13 with a history of a fall prior to admission, Weakness, Immobility, Rheumatoid Arthritis, and Neuropathy. The resident had a care plan with interventions for his/her increased need for ADL help, and for pain management.</p> <p>Observation, on 05/20/14 at 8:55 AM, revealed Resident #2 was abed, awake and alert, with his/her breakfast tray on the over-bed table. Resident #2 had finished eating, and he/she was receiving oxygen therapy per nasal cannula. Resident #2 was dressed in bed clothes, and had a neck pillow in place.</p> <p>Interview, on 05/20/14 at 8:56 AM, with Resident #2 revealed he/she had back pain from time to time related to a previous fall at home. Resident #2 stated his/her pain occurred mostly on exertion, when transitioning from a sitting to a standing position. Resident #2 stated he/she didn't call for pain medication needlessly, but said the nurses assessed her level of pain on a 1-10 scale. Resident #2 stated he/she took Tylenol for in-between pain, but knew something stronger was ordered, if needed. The resident stated the nurses had not refused to administer the stronger medicine when he/she asked for it.</p> <p>Review of Resident #2's MAR revealed the physician had ordered Hydrocodone 5/325 mg every six (6) hours, as needed. Review of the Pharmacy Corporation of America (PCA) Controlled Drug Record for Resident #2 revealed LPN #5 had signed out the Hydrocodone tablets numerous times from 01/01/14 to 05/04/14. During the month of January 2014, LPN #5 signed out thirteen (13) Hydrocodone 5/325mg tablets, as documented on Resident #2's Narcotic Administration Record (NAR). From 02/04/14 to</p>	F 431			



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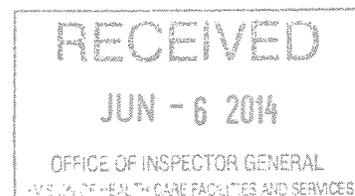
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F 431	<p>Continued From page 6</p> <p>05/04/14, LPN #5 signed out 22 Hydrocodone 5/325mg tablets on Resident #2's NAR.</p> <p>3. Review of Resident #1's clinical record revealed he/she was admitted to the facility on 05/20/13 with diagnoses of Intertrochanteric Fracture, and Aftercare for Hip Fracture. The resident had a care plan with interventions for his/her need for increased ADL help, and a care plan for pain management.</p> <p>Observation, on 05/20/14 at 9:20 AM, revealed Resident #1 was abed, awake and alert, and exhibited a pleasant affect. Resident #1's room was neat and homelike.</p> <p>Interview, on 5/20/14 at 9:20 AM, with Resident #1 revealed he/she had been admitted to the facility after a fall that occurred at home. Resident #1 stated he/she was satisfied with the care provided at the facility and that it was a nice place. Resident #1 denied having pain, and said he/she had not been experiencing pain. Resident #1 stated pain was not his/her problem, but was admitted to the facility because of an inability to live at home alone.</p> <p>Review of Resident #1's MAR revealed the physician had ordered Hydrocodone 5/325mg tabs 1-2 tabs every four (4) hours as needed. Review of the PCA Controlled Drug Record, for Resident #1, revealed 22 Hydrocodone 5/325mg tablets had been signed out by LPN #5, which included the following dates during that time period: 4 tabs on 05/03/14; 6 tabs on 05/04/14; 4 tabs 05/08/14; 4 tabs on 05/09/14; and 4 tabs on 05/13/14. Review of the Hydrocodone 5/325mg tablets signed out on 05/04/14 on Resident #1's NAR revealed LPN #5 signed out the</p>	F 431			



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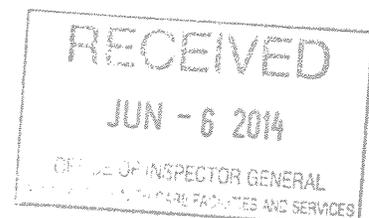
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F 431	<p>Continued From page 7</p> <p>Hydrocodone tablets earlier than the resident was supposed to have them. The time frames read as: Norco 2 tabs signed out at 8:52 AM; 12:30 PM, and 4:23 PM. Review of LPN #5's assessment/nurse's note on 05/04/14, did not reveal the resident had reported an increase in pain, or that LPN #5 had notified the physician related to an increase or change in the resident's level of pain. Continued review of Resident #1's NAR, from 12/02/13 to 05/13/14, revealed numerous sign outs of Hydrocodone 5/325mg by LPN #5.</p> <p>Interview, on 05/20/14 at 4:45 PM, with LPN #4 revealed she thought Resident #1 had a temporary increase in pain related to a flare up from a previous fracture, but that had been 2 or 3 months ago. LPN #4 further stated the resident had not complained of pain recently when she was assigned to care for him/her, at least not in the last month.</p> <p>4. Review of the clinical record for Unsampled Resident A, revealed the resident was admitted on 09/13/13 with a diagnosis of Intertrochanteric Hip Fracture. The surveyor was unable to interview the resident; however, review of the Unsampled Resident A's MAR revealed Hydrocodone/APAP 7.5/325 was ordered every 4 hours, as needed, for pain. Review of Unsampled Resident A's NAR revealed multiple sign-outs of Hydrocodone 7.5/325 mg for the resident from 12/01/13 to 05/13/14. Continued review of Unsampled Resident #A's clinical record (nurses' notes) did not reveal that LPN #5 documented the resident's pain level or other indicators that the resident was having pain.</p> <p>5. Review of the clinical record for Unsampled</p>	F 431			



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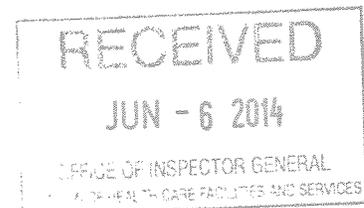
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F 431	<p>Continued From page 8</p> <p>Resident B revealed the resident was admitted to the facility on 09/03/13 with diagnoses of Chronic Obstructive Pulmonary Disease, and Fracture of the Femur. Review of the resident's MAR revealed the physician had ordered Hydrocodone APAP 5/325 mg every 4 hours, as needed, for pain. Review of the NAR for Unsampled Resident B revealed Hydrocodone 5/325mg had been signed out by LPN #5 multiple times from 11/16/13 to 05/09/14. Continued review of Unsampled Resident B's clinical record (nurses' notes) for that time period did not reveal the resident frequently scored on a pain scale or that the resident had displayed other frequent indicators he/she was experiencing pain.</p> <p>Interview, on 05/20/14 at 10:37 AM, with the Unit Manager (UM) for the facility's EOG unit, revealed a CMT was typically assigned to pass the residents' routine and prn pain medications. However, it had been noted from approximately 05/07/14 to 05/13/14, that LPN #5 had been offering to help the CMT with passing pain medications. The UM stated she knew the residents on her unit very well because she assisted with meal tray pass, answered call lights and conversed often with them and their family members. During a meeting with Resident #2's family member on 05/09/14, the UM stated the family member stated he did not think Resident #2 was was experiencing much pain, and requested the facility determine if the resident was taking the medication and requested discontinuation of the Hydrocodone, if appropriate, and for staff to discuss this potential change during Resident #2's upcoming care plan meeting. The UM stated she then questioned CMT #6, who usually administered Resident #2's medications, and CMT #6 told her the resident</p>	F 431			



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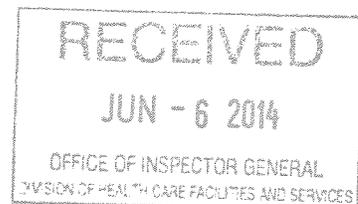
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F 431	<p>Continued From page 9</p> <p>had not been requesting the Hydrocodone, so she had not been giving it, but she thought LPN #5 had been giving it to the resident. The UM stated she reviewed the NARs for all other residents on the hallway, and noted a pattern in the signing out of Hydrocone by LPN #5 for 3 additional residents that had this medication ordered on an as needed basis. The UM stated she copied the NARs that showed this pattern of repeated sign-outs and took them to the ADON and the DON for their review.</p> <p>Interview, on 05/19/14 at 4:15 PM, with the facility's DON revealed after the UM provided copies of the residents' NARs to her, she immediately reported that information to the Administrator. The facility contacted the local police and after LPN #5 confessed she had taken the "as needed" Hydrocodone from the residents' supply, the facility began its own investigation/audit of the narcotic and medication records for residents on the EOG unit. The DON stated the audit revealed a pattern of sign-outs of Hydrocodone for 4 residents and this pattern ranged from October 2013 until the concern was reported to her.</p> <p>Interview, on 05/20/14 at 4:00 PM, with the Administrator, revealed that prior to this reported concern and the subsequent admission and her arrest of LPN #5, she had no reason to suspect LPN #5 would participate in any form of misappropriation of a resident's property. The Administrator stated residents had complimented LPN #5's work at the facility and she had kept the residents' positive statements on file as part of her Quality Assurance (QA) documentation.</p> <p>Continued interview with the Administrator</p>	F 431			



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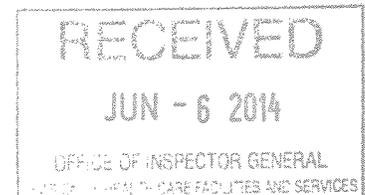
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F 431	<p>Continued From page 10</p> <p>revealed there had not been a specific system in place to detect repetitive signatures/patterns of suspicious behavior within the facility NARs, but there had been no previous reason to suspect this had been an issue. The Administrator stated that during the facility's investigation CMT #6 was interviewed, and she told the DON and the Administrator that she did not always remember to log out of the e-MAR system before LPN #5 signed out medications. The administrator stated once learning this, it was determined that CMT #6 should no longer pass medications at the facility. The Administrator further stated this break in standard of practice could have contributed to the multiple sign-outs of controlled substances by LPN #5.</p> <p>Review of the E-Med Pass CMT check off training tool, not dated, did not reveal a component specific to logging off the e-MAR system before giving another staff person access to the med cart.</p> <p>Interview, on 05/20/14, at 4:15 PM, with the Administrator revealed there was not a specific component within the e-MAR orientation tool about logging off the system, but she considered logging out of the E-MAR system a standard of practice for preventing other staff from signing out/administering medicines under one's own name. She likened it to the importance of the nurse always locking his/her med cart to protect its contents and the residents on the unit. The Administrator stated a component within the e-MAR orientation tool that ensured nurses/CMTs were oriented to and understood to log off the system, before giving another employee access to the cart, might strengthen understanding of this component of the med pass process.</p>	F 431			



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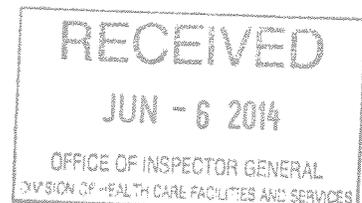
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F 431	<p>Continued From page 11</p> <p>The Administrator further stated the facility had conducted a Pain Management Systems review during November 2013, by reviewing records and pain assessments for 8 residents on each of the facility's 4 units. The Administrator said the findings were reviewed by the QA committee, and it was determined the facility was following its pain policies.</p> <p>Interview, on 05/20/14 at 2:40 PM, with the Staff Education Coordinator revealed employees new to the facility who were licensed/certified to administer medications, would be oriented to the Accu-Flow (e-MAR) system by their preceptors during the on-the-unit training. Updates to the Accu-Flow system would be provided to all staff assigned to administer and document medications they gave.</p> <p>Interview, on 05/21/14 at 8:20 AM, with RN #2 revealed she had oriented licensed/certified staff to administer medications, and this orientation included instruction on the e-MAR (Accu-Flow) system. RN #2 stated she instructed the orientee(s) to always lock the med cart when stepping away from it, and to close the lap top lid to hide residents' medical information. RN #2 stated she instructed the orientee (s) to never turn over their med cart keys to other staff members until shift change when a narcotic count was completed. She stated there was an e-MAR training check-off tool for orientees, but she could not remember if it had a section that specifically addressed ensuring the orientee(s) understood when to log out of the Accu-Flow system.</p> <p>Interview, on 05/21/14 at 8:50 AM, with UM #4 on the English Oak Terrace Unit, revealed she had</p>	F 431			



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F 431	<p>Continued From page 12</p> <p>not been instructed by the DON or other administrative staff to monitor the NAR on the med carts for repetitive sign-outs, or for any suspicious documentation by staff assigned to med pass. The UM stated this type of monitoring would assist in identifying any suspicious documentation and allow for rapid detection and follow up of any discrepancies or concerns. Continued interview with UM #4 revealed she had oriented new employees licensed or certified to administer medications. She stated she oriented them to the Accu-Flow system, and that they should log out of the system, and ensure the med cart was locked when they were going to be away from it. Orientees were instructed to keep the med cart keys in their possession until shift change because they were responsible for the cart's contents and their documentation. The UM stated if the nurse did not log out of the system, as required, another staff person could potentially sign out or administer medications under the credentials of the staff member who failed to log out.</p> <p>Interview, on 05/21/14 at 9:10 AM, with the DON revealed she had instructed all UMs to review the NARs on their units to identify any discrepancies or concerns with narcotic sign-outs. The DON stated the UMs were to determine if interviewable residents felt their pain had been controlled. The DON stated the UMs completed this process and no discrepancies were identified and there were no residents that reported their pain had not be sufficiently controlled.</p> <p>Interview, on 05/21/14 at 9:43 AM, with the facility's contracted Pharmacist, revealed she reviewed all residents' MARs on a monthly basis. If she determined an excessive amount of pain</p>	F 431		



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F 431	Continued From page 13 medication had been administered, she would contact the specific resident's physician and ask him/her to evaluate the pain medication regimen. Upon review of Resident #1's MAR for 05/03/14 to 05/13/14, the Pharmacist stated she probably would not have questioned the number of narcotics that had been signed out because there had been some days during that time frame when the Hydrocodone had not been signed out, and the documentation did not reveal the medication had been signed out every 4 hours, consistently, during each 24 hour period. The pharmacist stated a nurse employed by PCA conducted quarterly audits of the facility's med carts and NARs stored at the cart. The pharmacist retrieved the PCA nurse's most recent report, dated 02/16/14, and stated no concerns had been identified on the report regarding the facility's NARs.	F 431			

