

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

PRINTED: 06/26/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/12/2014
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NAME OF PROVIDER OR SUPPLIER  BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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**F 000** INITIAL COMMENTS

An Abbreviated Survey investigating KY00021796 was initiated on 06/10/14 and concluded on 06/12/14. KY00021796 was substantiated with related deficiencies cited at the highest Scope and Severity of a "D".

**F 281** 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

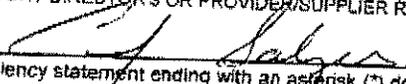
This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure Physician Orders were followed for one (1) of three (3) sampled residents (Resident #2). Interview with Resident #2 and record review revealed the resident did not receive three (3) scheduled doses of his/her pain medication as ordered for pain management on 05/24/14.

The findings include:  
Review of the facility's policy titled, "Medication Ordering and Receiving From Pharmacy-Ordering and Receiving Medications From the Dispensing Pharmacy", undated, revealed medications would be received from the dispensing pharmacy on a timely basis, so as to prevent a delay in medication administration. Further review revealed if the medication was needed before the next regular delivery, facility staff were to fax and phone in the medication order to the pharmacy immediately, and utilize the

**F 000** To the best of my knowledge and belief, as an agent of Boyd Nursing and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.

JUL 22 2014

**F281** It is the policy of Boyd Nursing and Rehabilitation Center to assure services provided or arranged by the facility shall meet professional standards of quality. Resident #2 received pain medications per physician order at 7:00 pm on 05/24/14. Physician orders were reviewed with no orders changed. All resident records for the previous 30 days were reviewed by the Director of Nursing Services, Staff Development Coordinator and RN Supervisor as of 06/30/14 to determine current orders were noted appropriately and implemented as directed by the physician according to Professional Standards of Practice.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7-22-14
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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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F 281	<p>Continued From page 1 emergency procedure for after hours ordering.</p> <p>Review of the facility's policy titled, "Medication Ordering and Receiving From Pharmacy-Emergency Pharmacy Services and Emergency Kits", undated, revealed the emergency pharmacy service was available on a twenty-four (24) hours basis. Continued review revealed if the medication was not available from the facility's emergency box, the nurse was to contact the pharmacy.</p> <p>Review of the facility's policy titled, "Medication Ordering and Receiving From Pharmacy-Ordering and Receiving Controlled Medications", undated, revealed it was the responsibility of the prescriber to provide a valid prescription to the pharmacy.</p> <p>Review of Resident #2's medical record revealed the facility re-admitted the resident on 02/25/14, with diagnoses which included Fracture of the Neck of the Femur, Muscle Weakness, Difficulty Walking and Chronic Pain. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/15/14, revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of eleven (11), indicating the resident was interviewable. Review of Resident #2's Comprehensive Care Plan revealed the resident was care planned for a history of chronic pain and long term narcotic use for pain control with a problem onset of 03/10/14. Continued review revealed interventions which included to administer pain medication as ordered, document the effectiveness of the medication and notify the Physician if adequate pain relief was not achieved.</p>	F 281	<p>All licensed nursing staff will be re-educated by the Director of Nursing Services and the Staff Development Coordinator on 07/10/14 regarding the following of Physician Orders with the importance of practicing all aspects of their profession according to Professional Standards of Practice. Additionally, the nursing staff will receive education regarding the protocols of the facility regarding pharmacy notification of medication refills and follow-up by the licensed nursing staff to ensure the system the facility has in place for medication administration is followed per the physician order and in accordance to the Professional Standards of Practice.</p> <p>Ten charts will be reviewed each business day for period of four weeks by either the Director Nursing Services, Health Information Management Coordinator (LPN), or the RN Supervisor to ensure physician orders are noted appropriately and implemented as directed by the physician. The review will be documented by using a Physician Order auditing tool (copy attached). The results of these audits will be forwarded to the weekly Focus Committee (consisting of the Director of Nursing Services, Staff Development Coordinator, Administrator, MDSC, Health Information Management Coordinator, RN Supervisor, Activities Director, Dietary Manager, and Social Services Director).</p>		

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F 281	Continued From page 2 Review of Resident #2's Physician Orders revealed an order dated 03/24/14, for Percocet (a narcotic pain reliever) 10/325 milligrams (mg) every six hours for pain. Review of the May 2014 monthly Physician Orders revealed the order for the Percocet 10/325 mg to be given every six hours, with a starting date of 03/24/14.  However, review of Resident #2's May 2014 Medication Administration Records (MARs) revealed the resident's ordered Percocet 10/325 mg was documented as not administered on 05/24/14 at 1:00 AM, 7:00 AM and 1:00 PM.  Review of the "Controlled Drug Record" for Resident #2 dated 05/07/14 revealed the last dose of the resident's Percocet was signed out on 05/23/14 at 7:00 PM, with zero doses remaining. Review of the "Controlled Drug Record" dated 05/24/14 at 3:00 PM revealed a count of sixty (60) Percocet.  Review of the "Narcotic Emergency House Stock" form which was undated revealed Oxycodone/APAP (Acetaminophen) 5/325 mg (generic for Percocet) was stocked on the cart.  Interview with Certified Medication Technician (CMT) #2 on 06/12/14 at 11:50 AM, revealed she had worked the 6:00 AM to 2:30 PM shift on 05/23/14 and when counting the narcotics she pulled the labels for Resident #2's refills as there were only one (1) or two (2) pills remaining at the end of shift count. She stated at she placed the pulled label from Resident #2's Percocet on the reorder form and faxed it to pharmacy. CMT #2 stated she always put the remaining number of doses of the medications left to alert the pharmacy. CMT #2 revealed if she was out of	F 281	The results of these audits will also be reviewed monthly by the QAPI Committee (consisting of the Administrator, Director of Nursing Services, MDSC, Staff Development Coordinator, Health Information Management Coordinator, Dietary Manager, Activities Director, Social Services Director, Physician, Pharmacist, and Maintenance Director) for further monitoring and continued compliance. The committee will determine, based on the results of audits received, how long monitoring should continue.	07/11/14

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F 281 Continued From page 3  
any medication she would get the medication from the emergency box if there was compatible medication, and if there was not a compatible medication she would tell the nurse.

Interview with CMT #3 on 06/12/14 at 11:49 AM, who worked the 2:00 PM to 10:30 PM shift on 05/23/14, revealed on 05/23/14 he had informed Registered Nurse (RN) #1 that he had given the last dose of Resident #2's Percocet to the resident at 7:00 PM. He stated RN #1 said he would "check into it". CMT #3 stated "if we are out of a medication we pull a medication from the emergency box" if the same medication was stocked.

Interview with RN #1/Charge Nurse on 06/11/14 at 4:15 PM and on 06/12/14 at 12:54 PM, revealed it was "possible" a CMT told him they were out of a resident's medication on 05/23/14. However, he stated he did not remember who the resident was as he got "distracted easily", had problems with his short term memory and with "people coming from all directions" and telling him "stuff". He stated if a medication was not available medication administration staff should check the emergency box and obtain an equivalent medication if available. RN #1/Charge Nurse stated if the same dose of medication was not available, the Physician should be called and an order obtained to give what was available. He stated he should have called the Physician on 05/23/14 in regards to Resident #2's Percocet. Further interview revealed the narcotic medications were "auto filled" and the pharmacy got the prescription from the Physician, although it was the responsibility of the nurse to follow-up as to why the medication was not available for administration.

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F 281	Continued From page 4  Interview with Resident #2 on 06/10/14 at 4:40 PM, revealed he/she was supposed to get Percocet 10/325 mg every six (6) hours; however, early in the morning on 05/24/14 when he/she was supposed to get the 1:00 AM dose, staff told him/her they were out of his/her Percocet. Resident #2 stated he/she called the pharmacy and told them this was the second time this had happened to him/her in regards to running out of his/her medication. Resident #2 revealed the staff did not do anything to relieve his/her pain during the time the pain medication was not available. Resident #2 reported he/she got "very anxious and nervous" when he/she did not receive the pain medication.  Interview with State Registered Nursing Assistant (SRNA) #1 on 06/12/14 at 10:30 AM, revealed Resident #2 turned on his/her call light early in the morning on 05/24/14, and requested his/her pain medication. SRNA #1 stated he went to Licensed Practical Nurse (LPN) #3 and told her. He stated LPN #3 told him they did not have any in stock. SRNA #1 revealed he told Resident #2 what LPN #3 had said about being out of his/her pain medication and the resident told him he/she was going to call the pharmacy himself/herself. SRNA #1 reported Resident #2 "got anxious" and then became "a little nervous" and he/she appeared in a "little discomfort" at that time.  Interview with LPN #3 on 06/11/14 at 5:00 PM, revealed Registered Nurse (RN) #1 told her he had placed a call to the on-call pharmacist at approximately 10:00 PM on 05/23/14. LPN #3 stated "we were waiting" for the medication to be delivered, but sometimes the pharmacy delivery was late.	F 281		

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F 281 Continued From page 5

Interview with CMT #1 on 06/11/14 at 11:40 AM, revealed on 05/24/14 there were no doses of Resident #2's Percocet to count and she informed LPN #1 of this information.

Interview with LPN #1 on 06/11/14 at 1:20 PM, who worked the 6:00 AM to 2:30 PM shift on 05/24/14, revealed CMT #1 had made her aware Resident #2 was out of his/her Percocet 10/325 mg on 05/24/14. LPN #1 stated the emergency box contained Oxycodone/APAP 5/325 mg and Resident #2 was on a 10/325 mg dose. She stated she called the pharmacy who told her they were trying to get in touch with the Physician for a prescription. She stated pharmacy staff also told her the facility would be receiving the Percocet as soon as they were able to get the Physician for the prescription. Further interview revealed she had tried to call the Physician herself, with no return call placed to the facility from the Physician. She stated she did not document that she had notified the pharmacy or the Physician; however, should have documented this information.

Interview with LPN #2 on 06/11/14 at 1:50 PM, who worked the 6:00 AM to 2:30 PM shift on 05/24/14, revealed CMT #1 had informed LPN #1 on 05/24/14 she needed to notify the pharmacy that Resident #2's Percocet was unavailable. LPN #2 stated LPN #1 notified the pharmacy and was told they needed a new prescription from the Physician who they were attempting to contact.

Interview, on 06/12/14 at 1:30 PM, with the Nurse Educator revealed she had acted in the Director of Nursing's role while the DON was off for the holiday weekend in May. The Nurse Educator

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F 281	Continued From page 6 revealed she was not notified of the unavailability of Resident #2's Percocet medication on 05/24/14. The Nurse Educator stated that should never have happened as there were emergency box medications available and if the medication or correct dose were not available in the emergency box the Physician should have been notified for orders. According to the Nurse Educator, the resident should not have gone without his/her pain medications as it was part of nursing's responsibility to ensure residents received their medications as ordered.	F 281	It is the policy of Boyd Nursing and Rehabilitation Center to ensure services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure staff provided care in accordance with each resident's Comprehensive Care Plan for one (1) of three (3) sampled residents (Resident #2). Resident #2 had a pain care plan with an intervention to administer pain medication as ordered. However, Resident #2's pain care plan was not followed when the resident did not receive three (3) scheduled doses of his/her pain medication when the medication was allowed to run out of doses.  The findings include:	F 282	The care plan for Resident #2 in regards to pain with an intervention to administer pain medications as ordered was reviewed by the IDCPT (consisting of the MDSC, Dietary Manager, Social Service Director and the Activities Director) on 06/13/14 and is reflective of resident's current needs. The plan of care for each resident will be reviewed by the IDCPT to ensure that the current plan of care is reflective of individual needs by 07/25/14. The plan of care will be utilized by the IDCPT via walking care plan rounds and chart reviews to ensure that all recorded interventions are implemented by 07/25/14.  All nursing staff will receive additional education by the Director of Nursing Service and the Staff Development Coordinator on 07/10/14 regarding the importance of implementation of the individual interventions.		

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F 282	<p>Continued From page 7</p> <p>Review of the facility's policy titled, "Comprehensive Plan of Care", dated 08/01/12 revealed all staff who provided care for residents were to be knowledgeable of and have access to the resident's care plan. Further review revealed it was the responsibility of each interdisciplinary team member involved in residents' care to provide input into the development, implementation and maintenance of the resident's care plan.</p> <p>Record review revealed the facility re-admitted Resident #2 on 02/25/14, with diagnoses which included Fracture of the Neck of the Femur, Muscle Weakness and Difficulty Walking. Review of the 05/15/14 Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #2 as having a Brief Interview for Mental Status (BIMS) score of eleven (11), indicating the resident was interviewable.</p> <p>Review of Resident #2's Comprehensive Care Plan, dated 03/10/14, revealed the resident was had a pain care plan related to his/her history of chronic pain and long term narcotic use for pain control. Review revealed interventions included; administering the resident's pain medications as ordered; observe for verbal and nonverbal indications of pain and investigate the cause; evaluate the resident's pain using the pain scale; ensure the resident was comfortable with every shift; assist the resident to reposition as needed to promote comfort; and notify the Physician if pain relief was not adequately achieved.</p> <p>Review of Resident #2's Physician Orders revealed on 03/24/14, the Physician ordered Percocet (a narcotic pain reliever) 10/325 milligrams (mg) every six (6) hours for pain.</p>	F 282	<p>The IDCPT received additional education by the Director of Nursing Services on 07/03/14 regarding the importance of ensuring implementation of individual interventions per resident chart reviews and via walking care plan rounds each week. The Director of Nursing Services or the Staff Development Coordinator will audit all scheduled care plans for four weeks and accompany the IDCPT during their chart reviews and walking care plan rounds. A care plan auditing tool will be utilized during this review (copy attached). Thereafter, the Director of Nursing will audit at least two care plans per week for 8 weeks to ensure implementation of interventions. The results of these audits will be forwarded to the weekly Focus Committee. These results will also be reviewed monthly by the QAPI Committee for further monitoring and continued compliance. The committee will determine, based on the results received, how long monitoring should continue.</p>	07/25/14	

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F 282	Continued From page 8 Review of the May 2014 Physician orders revealed the Percocet order present. However, review of the May 2014 Medication Administration Record (MAR) for Resident #2 revealed the medication was not administered on 05/24/14 at 1:00 AM, 7:00 AM and 1:00 PM.  Review of the "Controlled Drug Record" for Resident #2's Percocet dated 05/07/14, revealed the last dose of the resident's medication was signed out on 05/23/14 at 7:00 PM with no remaining doses. Review of the "Controlled Drug Record" dated 05/24/14 at 3:00 PM revealed a count of sixty (60) Percocet's.  Interview with Certified Medication Technician (CMT) #3 on 06/12/14 at 11:49 AM, revealed on 05/23/14 she informed Registered Nurse (RN) #1 she had administered Resident #2's last Percocet to him/her at 7:00 PM. CMT #3 stated RN #1 stated he would check on it. Further interview revealed if a medication was out of stock staff were to obtain the medication from the emergency box if the same medication was stocked in it. Review of the emergency box, "Narcotic Emergency House Stock" form which was undated, revealed the generic for Percocet was stocked in 5/325 mg dose.  Interview with RN #1/Charge Nurse on 06/11/14 at 4:15 PM and 06/12/14 at 12:54 PM, revealed a CMT had possibly told him they were out of a resident's medication, but he could not remember who the resident was. He indicated it was possible he had been told about Resident #'s Percocet being out of stock as he got "distracted easily" and had problems with his short term memory. RN #1/Charge Nurse revealed narcotics were "auto filled" by pharmacy who	F 282			

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F 282 Continued From page 9  
obtained the prescription from the Physician. He stated however, it was the nurses' responsibility to follow-up if the medication was not received. RN #1/Charge Nurse stated the facility had an emergency box with medications to use if a residents' medication was not available for administration. He reported if an equivalent for the medication was not available staff were to contact the Physician for an order to give what was available. He stated the Physician should have been called and indicated Resident #2 should have received pain medication as ordered per the care plan.

Interview with Resident #2 on 06/10/14 at 4:40 PM, revealed he/she was supposed to get his/her pain medication which was Percocet 10/325 mg every six (6) hours. Resident #2 stated however, early in the morning on 05/24/14, staff told him/her they were out of the pain medication. Resident #2 stated staff did not do anything to relieve his/her pain when his/her pain medication was not available. According to Resident #2, he/she got "very anxious and nervous" when he/she did not receive his/her Percocet.

Interview with State Registered Nursing Assistant (SRNA) #1 on 06/12/14 at 10:30 AM, revealed early in the morning on 05/24/14, Resident #2 rang the call light and requested his/her pain medication. He stated he told Licensed Practical Nurse (LPN) #3 and LPN #3 told him the resident's pain medication was out of stock. SRNA #1 stated he informed Resident #2 what LPN #3 told him regarding the pain medication being out of stock. According to SRNA #1, the resident "got anxious" and became "a little nervous" and appeared to be in a "little discomfort" when he told him/her about the pain

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/12/2014
NAME OF PROVIDER OR SUPPLIER  BOYD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102		
(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	
F 282	Continued From page 10 medication.  Interview with LPN #3 on 06/11/14 at 5:00 PM, revealed RN #1 had informed her he placed a call at approximately 10:00 PM on 05/23/14 regarding Resident #2's Percocet. She stated staff was waiting for the medication to be delivered, but sometimes pharmacy was late delivering medications.  Interview with CMT #1 on 06/11/14 at 11:40 AM, who worked on 05/24/14 on the 6:00 AM to 2:30 PM shift, revealed Resident #2 had no Percocet's available to count on 05/24/14 when she arrived to work. She stated she told LPN #1 about this. there was no medication for Resident two (#2) to count, I then informed Licensed Practical Nurse one (#1).  Interview with LPN #1 on 06/11/14 at 1:20 PM, who worked on 05/24/14 on the 6:00 AM to 2:30 PM shift, revealed CMT #1 had informed her of being out of Resident #2's Percocet on 05/25/14. She stated the emergency box contained generic Percocet in a 5/325 mg dose; however, Resident #2 was on 10/325 mg dose. She stated she attempted to call the Physician for orders, but the Physician had not called back. She reported she had not documented her attempt which she should have done. LPN #1 indicated she did not attempt any additional measures to ensure Resident #2's pain was relieved.  Interview with LPN #2 on 06/11/14 at 1:50 PM, revealed CMT #1 had informed LPN #1 about being out of Resident #2's pain medication. LPN #2 stated Resident #2 should not have been left in pain while waiting for the pain medication to be obtained from pharmacy.	F 282			

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Interview with MDS Coordinator on 06/12/14 at 2:34 PM, revealed Resident #2's pain care plan had not been followed by staff; however should have been.

Interview with the Nurse Educator, who was the acting Director of Nursing (DON) when the incident related to Resident #2's pain medication occurred, on 06/12/14 at 1:30 PM and 2:50 PM, revealed staff should have notified the Physician on 05/24/14 when Resident #2's pain medication was out of stock. She stated the resident should never have had to go without his/her pain medication. The Nurse Educator revealed Resident #2's pain care plan had not been followed by staff regarding the administration of pain medication as ordered; however, should have been.

Interview with the Director of Nursing (DON) on 06/12/14 at 10:10 and 3:40 PM revealed that nineteen and a half hours was too long for Resident #2 to go without his/her scheduled pain medication. The DON stated the nurses should have called the on-call Pharmacist and notified the Physician when the pain medication was not available. Further interview revealed staff had not followed Resident #2's pain care plan to administer pain medication as ordered; however should have.

Interview with the Administrator on 06/12/14 at 10:45 AM, revealed staff should have obtained pain medication for Resident #2 out of the emergency box, and should have call the pharmacy and notified the Physician. The Administrator indicated staff did not follow Resident #2's care plan for administering pain

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F 282	Continued From page 12 medication as ordered; however, should have followed it.	F 282		
F 425 SS=D	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.  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.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide routine medications, as ordered by the physician, for one (1) of three (3) sampled residents. Resident #2 did not receive three (3) scheduled doses of Percocet 10/325 milligrams (mg) on 05/24/14 at 1:00 AM, 7:00 AM and 1:00 PM, due to the medication being unavailable for administration to the resident. (Percocet is a	F 425	It is the policy of Boyd Nursing and Rehabilitation Center to provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement. Resident #2 received pain medication per physician order at 7:00 pm on 05/24/14. Physician orders were reviewed with no changes noted. All resident medication administration records for the previous 30 days will be reviewed by the Director of Nursing Services, the Staff Development Coordinator and the RN Supervisor as of 07/25/14 to determine scheduled medications were administered by licensed nursing staff in accordance with physician orders. The Director of Nursing Services and Pharmacy Consultant reviewed policies "Medication Ordering and Receiving from Pharmacy - Ordering and Receiving Medications from the Dispensing Pharmacy", and "Medication Ordering and Receiving from Pharmacy - Emergency Pharmacy Services and Emergency Kits" on 07/03/14 No changes were made to these policies.	

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F 425 : Continued From page 13  
narcotic pain reliever.)

The findings include:

Review of the facility's policy (undated), titled "Ordering and Receiving Medications from the Dispensing Pharmacy", revealed medications would be received from the dispensing pharmacy on a timely basis, to prevent a delay in medication administration.

Clinical record review revealed the facility admitted Resident #2 on 02/25/14 with diagnoses which included Status Post Fractured Neck of Femur (broken leg), Muscle Weakness, Congestive Heart Failure, and Hypertension. Review of the Brief Interview for Mental Status (BIMS), dated 05/15/14, revealed Resident #2 scored eleven (11) of a possible fifteen (15), which indicated moderate cognitive impairment. Review of the comprehensive Care Plan, dated 03/10/14, revealed interventions were in place related to Resident #2's history of chronic pain and long-term narcotic use.

Review of the Physician Orders for Resident #2 revealed an order, dated 03/24/14, for Percocet 10/325 mg every six hours for pain.

Review of the e-MAR (electronic Medication Administration Record) for May 2014 revealed Resident #2 did not receive Percocet 10/325 mg, as ordered, on 05/24/14 at 1:00 AM, 7:00 AM and 1:00 PM.

Review of the Controlled Drug Record for Resident #2, dated 05/07/14, revealed the last dose of Percocet was signed out on 05/23/14 at 7:00 PM, with a zero balance remaining.

F 425 : All Nursing staff were re-educated by Staff Development regarding following the policies of "Medication Ordering and Receiving from Pharmacy - Ordering and Receiving Medications from the Dispensing Pharmacy" and "Medication Ordering and Receiving from Pharmacy - Emergency Pharmacy Services and Emergency Kits" on 07/10/14 in accordance to providing routine and emergency drugs and biologicals to our residents.

All Medicare Pharmacy staff were re-educated by the Medicare Director of Operations on 06/16/14 on proper procedure for completion of cycle fill box for all routine orders to ensure system process works efficiently for refill orders.

Medicare Pharmacy will conduct audits on all of this facilities routine prescription orders for the next 4 weeks to ensure that the cycle fill box is checked and the system is working properly for all refill orders. Copy of the audit tool is attached. Any discrepancies from this audit will be reviewed by the MedCare Director of Operations to determine additional follow-up that may be required. Notification will be made by the MedCare Director of Operations to the facility Administrator and Director of Nursing Services concerning this discrepancy to determine additional follow-up that may be required by the facility.

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F 425	<p>Continued From page 14</p> <p>Continued review of the Controlled Drug Record, dated 05/24/14, revealed a count of sixty (60) Percocet for Resident #2 was added to the inventory on 05/24/14 at 3:00 PM.</p> <p>Interview with the Pharmacy Consultant, on 06/12/14 at 8:48 AM, revealed there was not a written policy to ensure residents received their medications before the medication ran out. The consultant explained narcotics were auto filled up to fourteen days before the prescription expired; normally, the refill was generated in seven (7) to ten (10) days, to allow time for the Physician to submit a prescription to the Pharmacy. He stated it was a good system and the Pharmacy usually delivered medications one (1) to two (2) days in advance, but failed to do so for Resident #2, which resulted in the resident having no Percocet available for administration on 05/24/14. Continued interview revealed the Consultant did not know how Resident #2's Percocet refill slipped up on them; he could not see where it "fell through the cracks".</p>	F 425	<p>The Director of Nursing Services, Health Information Management Coordinator, or the RN Supervisor will monitor ten percent of daily census medication administration records for review of all scheduled medication administration accordance to the physician order daily Monday through Friday for a period of four weeks then once a week for an additional four weeks. A copy of the audit tool is attached. The results of these audits will be forwarded to the weekly Focus Committee. Results will also be reviewed monthly by the QAPI Committee for further monitoring and continued compliance. The committee will determine, based on the results of audits received, how long monitoring should continue.</p>	07/25/14