

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/19/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218
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F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00167984, Complaint IN00169085 and Complaint IN00169655.</p> <p>Complaint IN00167984 -- Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00169085 -- Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00169655 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, F332, F425, F431 and F441.</p> <p>Survey dates: March 16, 17, 18 and 19, 2015</p> <p>Facility number: 000500 Provider number: 155557 AIM number: 100266220</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 10 SNF/NF: 58 Total: 68</p> <p>Census payor type: Medicare: 12</p>	F 000	<p>Kim Rhoades Director, Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Survey Event ID 6G0311 Dear Ms. Rhoades: Please accept the enclosed plan of correction as credible allegation of compliance to the deficiencies cited during our Annual Health Survey conducted on March 19, 2015 at Miller's Merry Manor, in Indianapolis. Hopefully, you will find that our remedies are both sufficient and thoroughly explained in providing you a clear picture of how we corrected these concerns. With this submission of these remedies, <i>we are requesting paper compliance</i>. If, after reviewing our plan of correction, you have any questions or require further information, please do not hesitate to contact me at your convenience at (317) 357-8040. Respectfully submitted, Paula Juday Administrator</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 157 SS=D Bldg. 00	<p>Medicaid: 42 Other: 14 Total: 68</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed March 25, 2015 by Cheryl Fielden, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member</p>			

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	<p>when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, two facility staff members failed to timely notify/inform the Director of Nursing (DON) and/or the Administrator of a resident's statement of receiving incorrect medication in order to allow the prompt initiation of an investigation into the circumstances of the allegation of a medication error for 1 of 6 residents reviewed for correct administration of medications. This deficient practice has the potential to adversely all residents who are administered medications by facility. (Resident #D)</p> <p>Findings include:</p> <p>In an interview with Resident #D on 3-19-15 at 10:25 a.m., he indicated during the early morning hours of 3-4-15, he was awakened by an unknown staff member and told he had received the IV antibiotic meant for another resident inadvertently. To the best of his knowledge he has no medication allergies and did not suffer any negative</p>	F 157	<p>F157 NOTIFY OF CHANGES (INJURY/DCLINE/ROOM, ETC.) It is the policy of this facility that possible medication errors must be reported immediately to the DON, attending physician, and responsible party. To correct this deficiency: · DON and Administrator notified on 3/17/15 of possible medication error. Investigation initiated; medical director notified; resident aware (per: telephone call from Administrator to Resident D on 3/19/15). Resident #D has discharged from facility. All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected: · 100% audit of residents utilizing IV antibiotic therapy to ensure that no other residents on IV therapy had a possible medication error that went unreported to the DON / physician. No other resident were affected. To prevent recurrence: · All nurses will be in-services on or before 4/1/15 on the policy and procedure for Medication Error · DON or Designee will ask 3 random nurses daily if they are</p>	04/01/2015

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	<p>consequences from this alleged error. He indicated after this incident, he told several nurses about it when they would come in to give him his next dose of IV antibiotic. He indicated he could only recall the first name of one of the nurses, RN #1, who worked evening shift. He indicated RN #1 was always very careful to check the labels of the IV medicine prior to providing the medication.</p> <p>He indicated the 3-11-15, afternoon dose of his IV antibiotic looked different to him than the previous times, as the label attached to the medication "ball" looked different to him. He indicated he then looked more closely at the label and it had the name of Resident #E, and the medication name listed was "Cubicin, "which was different than the name of the medication he had been receiving. At this point, he recalled he took several pictures with his phone of the label which had the other person 's name and medication name, but didn ' t have the date and time of the dose in the picture. He then "clamped the medicine off and called the nurse to come and change the medicine." He again indicated he could not recall the name of the nurse who had provided the medication or changed the medication. He speculated the medication had been infusing a total of 4 to 5 minutes. "Who would have thought</p>		<p>aware of any medication errors. This will be included on the QA tool titled "Medication Error". This will be started on or before 4/1/15. · DON or Designee will observe 1 med pass daily to monitor for medication errors. · The DON or Designee will monitor compliance using the QA Tool titled "Medication Error" daily X30 days, weekly X4, monthly X3, and quarterly thereafter. This QA Tool will be started on or before 4/1/15. <i>Attachments: Medication & Treatment Error Procedure (1-A), QA Tool "Medication Error Review" (1-B).</i></p>		

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	<p>I would end up with the wrong medicine twice within barely a week?"</p> <p>In an interview with a family member of Resident #D on 3-17-15 at 3:45 p.m., she indicated Resident #D had informed her he had received the wrong IV antibiotic during the night shift of 3-4-15 by an unknown staff member. She indicated she spoke with an unknown nurse around this time and the nurse did not know what the erroneous medication name was. She indicated a second problem occurred around 3-11-15 when Resident #D noticed the label on his IV antibiotic had another person 's name on it and the name of the medication was different than what he had been receiving. She indicated he took a picture of the label with his phone and called the nurse to check the medication. She indicated this happened on the night shift. She indicated the IV antibiotics were administered on an every 8 hour basis. She indicated Resident #D could not provide a name or description of any nurses involved. She indicated she did not think he had any adverse reactions to the medication problems. Neither the resident nor the family member contacted the facility regarding the errors. She indicated Resident #D is "not the type of person that would ever bring up such a thing with the nursing home. He</p>			

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	<p>wouldn ' t say anything; wouldn ' t want to cause a problem."</p> <p>In an interview with the DON on 3-17-15 at 2:20 p.m., she indicated she was unaware of any medication errors or discrepancies of any kind for Resident #D.</p> <p>In an interview with LPN #2 on 3-18-15 at 12:25 p.m., she indicated on the last day of Resident #D's IV antibiotic, she went in to give him his antibiotic. "He told me to check it really carefully because the day before, someone had given him the wrong medicine. Yesterday, [3-17-15] they [facility administration] called me and wanted to know if I knew anything about this. I told them what I told you. They asked about what I would do if I had made a med error. I told them I would monitor the resident, let the doctor know and let the DON know. They told me I should have done the same thing with getting a report about an error, too. I did ask the resident if he had had any problems and he said no he hadn ' t."</p> <p>In a written statement, dated 3-18-15 and signed by LPN #2, she indicated on an unspecified date, she had gone into Resident #D's room to administer his medication of an IV antibiotic when the</p>			

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	<p>resident told her to check the medication as he had been given someone else's medication the night before. She indicated she asked the resident whose medication was received, was it the full dose, which nurse had done this, but the resident could not answer those questions. He, however, was able to tell her he had no adverse reactions. She indicated this information regarding a medication error was not provided to her by facility staff prior to beginning her shift on that date or since.</p> <p>In a written statement from RN #3, dated 3-18-15, she indicated she had been told by a fellow nurse that Resident #D had received the wrong IV antibiotic.</p> <p>In a written statement, dated 3-17-15 and signed by RN #1, she indicated on an unknown date, Resident #D "showed me a picture on his phone white medication label," and the resident told her, 'I called the nurse when I saw the other person's name on it. It only ran for 3 minutes. The nurse stopped it, left my room. When she came back [sign for with] the right one...She said I called the Dr. and we are going to observe you.'</p> <p>In an interview with the DON on 3-18-15 at 10:45 a.m., she indicated once learning of the possible medication error the day</p>			

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	<p>before, an investigation was begun immediately and thus far no one had admitted to giving the wrong IV medication to Resident #D. The only other resident receiving IV antibiotics during the time in question was Resident #E.</p> <p>On 3-19-15 at 8:45 a.m., the DON provided a copy of a policy and procedure entitled, "Medication and Treatment Error Procedure." This document had a policy start date of 9-17-13, and was indicated to be the current policy utilized by the facility. This policy indicated, "Purpose: To safeguard the resident...Procedure: Medication errors and drug reactions must be reported immediately to the attending physician and responsible party. An entry of the incident must be made in the resident's clinical record, and the medication error report. The charge nurse is responsible for generating a report, describing the incident and action taken, and notify the Director of Nursing immediately. The resident is kept under close observation. Observe for reactions for at least 24 to 48 hours. Changes in condition will be reported to the physician and family..."</p> <p>The Federal tag relates to Complaint IN00169655.</p>			

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F 282 SS=D Bldg. 00	<p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>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.</p> <p>Based on record review, the facility failed to ensure the accuracy of a medication order transcription which resulted in 1 of 6 residents reviewed for accuracy of medication administration receiving an antibiotic incorrectly. This deficient practice has the potential to create a negative effect on the resident by receiving an incorrect or untimely medication. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's clinical record was reviewed on 3-17-15 at 11:30 a.m. His diagnoses included recurrent left knee septic arthritis.</p> <p>In review of the hospital discharge orders, dated 2-20-15, for admission to the nursing facility, it indicated, "Cefazolin Inj [injection] 2 g [grams]</p>	F 282	<p>F282 SERVICES BY QUALIFIED PERSONS / PER CARE PLAN It is the policy of this facility that physician orders are transcribed and maintained in a manner that ensures safety upon administration. To correct this deficiency: · DON and Administrator notified on 3/17/15 of transcription error. Resident #D has discharged from the facility. All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected: · 100% audit of residents admission orders within the past 30 days to ensure that no further transcription errors occurred upon admission. This was completed on 3/31/15. To prevent recurrence: · All nurses will be in-services on or before 3/31/15 on the policy and procedure for Physician Order Transcription Procedure. · All nurses will utilize a 3 step process for</p>	04/01/2015

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	<p>IVSP q8h [intravenously every 8 hours] through at least 3/4/15 to complete 2 weeks of IV therapy. ID [infectious disease] group will assess at f/u [follow up] appt on 3/4/15...Cephalexin 500 mg [milligrams] tab, take 1 tablet (500 mg) by oral route every 6 hours. This order will be contingent on the orders received from [name of specific physician] at appt on 3/4/15."</p> <p>In review of the facility admission orders, dated 2-20-15, transcribed by facility staff, it indicated, "Cefazolin Inj. 2 g IVSP q8 [symbol for hour] to end on 3-5-15 [for] L [left] knee infection." A second entry indicated, "Cephalexin 500 mg tab 1 tab po [by mouth] q6 [symbol for hour], start 3/4/15 [for] L knee infection."</p> <p>Review of a fax, dated 3-4-15, with a facility receipt stamped time of 7:26 p.m., from a Infectious Disease physician, indicated to continue the same dose of Cefazolin at the same dose and frequency through 3-11-15, and, "Do not start Keflex [also known as Cephalexin]."</p> <p>Review of the March, 2015, Medication Administration Record [MAR] indicated Resident #D received 3 doses of the Cephalexin on 3-4-15, received at 12:00 a.m., 6:00 a.m. and 12:00 p.m. A</p>		<p>ensuring accuracy of admission orders including: 1. Admitting nurse will transcribe admission orders. 2. A second nurse will verify accuracy of admitting orders 3. Unit manager or designee will review for accuracy. · The DON or Designee will monitor compliance using the QA Tool titled "Physician Order Transcription Review" daily X30 days, weekly X4, monthly X3, and quarterly thereafter. This QA Tool will be started on or before 4/1/15. <i>Attachments: Physician Order Transcription Procedure (2-A), QA Tool "Physician Order Transcription Review" (2-B) .</i></p>	

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F 332 SS=E Bldg. 00	<p>handwritten note on the MAR clarified to discontinue this medication, effective 3-5-15.</p> <p>The Federal tag relates to Complaint IN00169655.</p> <p>3.1-35(g)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure facility staff properly administer medications to all residents, including, but not limited to 1 of 10 residents observed during 1 of 3 medication passes with 4 nursing staff, resulting in 2 errors in 28 doses observed for an error rate of 7.14%. This deficient practice suggests a higher than expected error rate that could potentially adversely effect all residents in the facility receiving medications from facility staff. (Resident #F)</p> <p>Findings include:</p> <p>In a medication pass observation on 3-18-15 at 1:42 p.m. with LPN #9 for</p>	F 332	<p>F332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE It is the policy of this facility that there is a physician's order stating is acceptable to crush tablets or open medication tablets when appropriate and to contact physician for an alternate medication when not appropriate. To correct this deficiency: · DON and Administrator notified on 3/18/15 of medication error with crushed tablet of Diltiazem and opened capsule of Neurotin. Resident is able to take medication whole; DO NOT CRUSH was added to his MAR on 3/18/15 for Diltiazem and Neurotin. All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected: · 100% audit of MARs to ensure</p>	04/01/2015

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	<p>Resident #F, she was observed to obtain a packet of medication containing one tablet of diltiazem 60 mg (milligrams). She indicated, "I don't think we are supposed to crush the diltiazem, but we do," as she was observed to place the medication packet into the pill crusher and crush the medication. She then placed the crushed medication into a medication cup with applesauce in it. She then obtained a medication packet containing one capsule of gabapentin 600 mg. She was observed to remove the capsule with bare, ungloved hands and empty the contents of the capsule into the medicine cup of applesauce.</p> <p>Upon completion of administering the medications to the resident, LPN #9 indicated she should have worn gloves to empty the capsule into the applesauce. She then looked through the Medication Administration Record (MAR) book for a list of medications that should not be crushed. She indicated she was unable to locate such a list.</p> <p>Review of the March, 2015, recapitulation orders included an order with a date of 9-21-14, which indicated, "May crush meds prn [as needed] if pharmaceutically appropriate and administer in food/fluid."</p>		<p>that each MAR contains a DO NOT CRUSH list of medications.</p> <ul style="list-style-type: none"> · All nurses in-serviced on DO NOT CRUSH list of medications by 3/31/15. To prevent recurrence: · All nurses will be in-serviced on or before 3/31/15 on the policy and procedure for Medication Administration, including the DO NOT CRUSH medication list. · DON or Designee will do a daily audit of each MAR in the facility to ensure that the "DO NOT CRUSH" list is on the MAR. This will be included in the "Medication Error Review" · DON or Designee will observe 1 med pass daily to monitor for medication errors including DO NOT CRUSH medications · The DON or Designee will monitor compliance using the QA Tool titled "Medication Error Review" daily X30 days, weekly X4, monthly X3, and quarterly thereafter. This QA Tool will be started on or before 4/1/15. It is also the policy of this facility to not touch medications with hands. To correct this deficiency: · DON and Administrator notified on 3/18/15 of medication touched with bare hands during med pass. · DON provided immediate education to LPN #9 regarding the Medication Administration Procedure All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected: · LPN #9 immediately educated to not 	

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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
	<p>On 3-19-15 at 8:45 a.m., the Director of Nursing (DON) provided a copy of Resident #F's current MAR for March, 2015, related to the diltiazem. The order for diltiazem 60 mg one tablet three times daily by mouth included a handwritten note indicating, "DO NOT CRUSH."</p> <p>On 3-19-15 at 8:45 a.m., the DON provided a copy of a policy/procedure entitled, "Medication Administration." This document was dated 10-4-12 and was identified as the current policy/procedure utilized by the facility. It indicated, "...Do not touch tablets with hands...Altering of medication: Ensure that there is a physician's order stating it is acceptable to crush tablets or open medication capsules and give with food substance. If a medication should not be crushed or altered contact physician for an alternate medication or liquid equivalent..."</p> <p>On 3-19-15 at 10:05 a.m., the DON provided a copy of a document entitled, "Medications Not To Be Crushed." This document had a revision date of 1/2012. It indicated diltiazem tablets should not be crushed due the crushing process "will alter the controlled-release mechanism resulting in instant release of drug which may cause faster absorption, earlier time to max concentration and higher max</p>		<p>touch medication with bare hands during med pass. To prevent recurrence: · All nurses will be in-serviced on or before 3/31/15 on the policy and procedure for Medication Administration, including not touching tablets with bare hands. · DON or Designee will do a daily audit of each MAR in the facility to ensure that the "DO NOT CRUSH" list is on the MAR. This will be included in the "Medication Error Review" · DON or Designee will observe 1 med pass daily to monitor for medication errors including DO NOT CRUSH medications and proper hand hygiene. · The DON or Designee will monitor compliance using the QA Tool titled "Medication Error Review" daily X30 days, weekly X4, monthly X3, and quarterly thereafter. This QA Tool will be started on or before 4/1/15. <i>Attachments: Medication Administration Policy and Procedure (3-A), QA Tool "Medication Error Review" (3-B) .</i></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155557	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/19/2015
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F 425 SS=D Bldg. 00	<p>concentration. The duration of effect might be decreased necessitating more frequent dosing when tablets are crushed. Patients who are administered crushed tablets should be closely monitored for exaggerated effect."</p> <p>"Cardizem (diltiazem hydrochloride) Tablets" (November, 2014) was retrieved on 3-19-15, from the U.S. Food and Drug Administration's website. The safety precautions instructed to give diltiazem tablets whole and not to split, crush or chew the tablets as the medication is formulated to release slowly.</p> <p>"Neurontin (gabapentin) Capsules" (2011) was retrieved on 3-25-15, from the U.S. Food and Drug Administration's website. The site indicated, "If taking capsules, always swallow them whole with plenty of water."</p> <p>This Federal tag relates to Complaint IN00169655.</p> <p>3.1-25(b)(9)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its</p>			

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	<p>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. Based on observation, interview and record review, the facility failed to ensure facility staff properly administer medications in that only medications that can be safely crushed for administration and medications are not touched by bare hands when being opened for administration are provided to residents for 1 of 10 residents observed during 1 of 3 medication passes with 4 nursing staff. This deficient practice has the potential to expose the resident to unknown pathogens or unexpected or undesired effects of the medication. (Resident #F)</p> <p>Findings include:</p> <p>In a medication pass observation on 3-18-15 at 1:42 p.m. with LPN #9 for</p>	F 425	<p>F 425 PHARMACEUTICAL SVC.</p> <p>It is the policy of this facility that there is a physician's order stating is acceptable to crush tablets or open medication tablets when appropriate and to contact physician for an alternate medication when not appropriate. To correct this deficiency: · DON and Administrator notified on 3/18/15 of medication error with crushed tablet of Diltiazem. Resident is able to take medication whole; DO NOT CRUSH was added to his MAR on 3/18/15 for Diltiazem and Neurotin. All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected:</p>	04/01/2015

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	<p>Resident #F, she was observed to obtain a packet of medication containing one tablet of diltiazem 60 mg (milligrams). She indicated, "I don't think we are supposed to crush the diltiazem, but we do," as she was observed to place the medication packet into the pill crusher and crush the medication. She then placed the crushed medication into a medication cup with applesauce in it. She then obtained a medication packet containing one capsule of gabapentin 600 mg. She was observed to remove the capsule with bare, ungloved hands and empty the contents of the capsule into the medicine cup of applesauce.</p> <p>Upon completion of administering the medications to the resident, LPN #9 indicated she should have worn gloves to empty the capsule into the applesauce. She then looked through the Medication Administration Record (MAR) book for a list of medications that should not be crushed. She indicated she was unable to locate such a list.</p> <p>Review of the March, 2015, recapitulation orders included an order with a date of 9-21-14, which indicated, "May crush meds prn [as needed] if pharmaceutically appropriate and administer in food/fluid."</p>		<ul style="list-style-type: none"> · 100% audit of MARs to ensure that each MAR contains a DO NOT CRUSH list of medications. · All nurses in-serviced on DO NOT CRUSH list of medications by 3/31/15. <p>To prevent recurrence:</p> <ul style="list-style-type: none"> · All nurses will be in-serviced on or before 3/31/15 on the policy and procedure for Medication Administration, including the DO NOT CRUSH medication list. · DON or Designee will do a daily audit of each MAR in the facility to ensure that the "DO NOT CRUSH" list is on the MAR. This will be included in the "Medication Error Review" · DON or Designee will observe 1 med pass daily to monitor for medication errors including DO NOT CRUSH medications · The DON or Designee will monitor compliance using the QA Tool titled "Medication Error Review" daily X30 days, weekly X4, monthly X3, and quarterly thereafter. This QA Tool will be started on or before 4/1/15. 	

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	<p>On 3-19-15 at 8:45 a.m., the Director of Nursing (DON) provided a copy of Resident #F's current MAR for March, 2015, related to the diltiazem. The order for diltiazem 60 mg one tablet three times daily by mouth included a handwritten note indicating, "DO NOT CRUSH."</p> <p>On 3-19-15 at 8:45 a.m., the DON provided a copy of a policy/procedure entitled, "Medication Administration." This document was dated 10-4-12 and was identified as the current policy/procedure utilized by the facility. It indicated, "...Do not touch tablets with hands...Altering of medication: Ensure that there is a physician's order stating it is acceptable to crush tablets or open medication capsules and give with food substance. If a medication should not be crushed or altered contact physician for an alternate medication or liquid equivalent..."</p> <p>On 3-19-15 at 10:05 a.m., the DON provided a copy of a document entitled, "Medications Not To Be Crushed." This document had a revision date of 1/2012. It indicated diltiazem tablets should not be crushed due the crushing process "will alter the controlled-release mechanism resulting in instant release of drug which may cause faster absorption, earlier time to max concentration and higher max</p>		<p>It is also the policy of this facility to not touch medications with hands. To correct this deficiency:</p> <ul style="list-style-type: none"> DON and Administrator notified on 3/18/15 of medication touched with bare hands during med pass. DON provided immediate education to LPN #9 regarding the Medication Administration Procedure <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected:</p> <ul style="list-style-type: none"> LPN #9 immediately educated to not touch medication with bare hands during med pass. <p>To prevent recurrence:</p> <ul style="list-style-type: none"> All nurses will be in-serviced on or before 3/31/15 on the policy and procedure for Medication Administration, including not touching tablets with bare hands. DON or Designee will do a daily audit of each MAR in the facility to ensure that the "DO NOT CRUSH" list is on the MAR. This will be included in the "Medication Error Review" DON or Designee will observe 1 med pass daily to 	

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F 431 SS=D Bldg. 00	<p>concentration. The duration of effect might be decreased necessitating more frequent dosing when tablets are crushed. Patients who are administered crushed tablets should be closely monitored for exaggerated effect."</p> <p>"Cardizem (diltiazem hydrochloride) Tablets" (November, 2014) was retrieved on 3-19-15, from the U.S. Food and Drug Administration's website. The safety precautions instructed to give diltiazem tablets whole and not to split, crush or chew the tablets as the medication is formulated to release slowly.</p> <p>"Neurontin (gabapentin) Capsules" (2011) was retrieved on 3-25-15, from the U.S. Food and Drug Administration's website. The site indicated, "If taking capsules, always swallow them whole with plenty of water."</p> <p>This Federal tag relates to Complaint IN00169655.</p> <p>3.1-25(b)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt</p>		<p>monitor for medication errors including DO NOT CRUSH medications and proper hand hygiene.</p> <p>The DON or Designee will monitor compliance using the QA Tool titled "Medication Error Review" daily X30 days, weekly X4, monthly X3, and quarterly thereafter. This QA Tool will be started on or before 4/1/15.</p> <p><i>Attachments: Medication Administration Policy and Procedure (4-A), QA Tool "Medication Error Review" (4-B)</i></p>		

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	<p>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 quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure a liquid narcotic medication had appropriate labeling to include the concentration of the medication for 1 of 10 residents observed during 1 of 3 medication passes with 4 nursing staff. This deficient practice has the potential to create difficulty in properly calculating</p>	F 431	<p>F 431 DRUG RECORDS, LABEL/STORE & BIOLOGICALS</p> <p>It is the policy of this facility that each medication label includes strength of medication and that liquids include strength per ml. To correct this deficiency:</p> <p>· DON and Administrator</p>	04/01/2015

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	<p>the physician-ordered dosage for the resident. (Resident #G)</p> <p>Findings include:</p> <p>During a medication pass observation with RN #4 on 3-18-15 at 9:25 a.m., RN #4 was observed to prepare to pour the morning dose of hydrocodone with acetaminophen 7.5/325 mg (milligrams) for Resident #G. The bottle was labeled with appropriate details of the date dispensed, the prescription number, the resident's name, name of the medication, the prescribing physician's name and directions to administer the liquid medication. The labeling did not include the concentration of the medication to the liquid. When this was identified, RN #4 phoned the dispensing pharmacy to clarify the issue. She indicated she had spoken with a Pharmacy Technician who informed her the current order was an old order, meaning it was current and on-going for some time and the label did not have room to place the concentration on the label.</p> <p>In a phone interview with a Registered Pharmacist at the contracted pharmacy on 3-18-15 at 10:20 a.m., she indicated the bottle 's label should have the concentration listed on it as it is standard practice to place the concentration of the</p>		<p>notified on 3/18/15 of labeling error. Physician notified immediately and order received for same dose in pill form until able to rectify labeling issue with pharmacy.</p> <ul style="list-style-type: none"> · Pharmacy contacted immediately and notified of error. · Same medication obtained same day from back up pharmacy · DON returned medication to pharmacy · Pharmacy dispensed medication with corrected label. <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected:</p> <ul style="list-style-type: none"> · 100% audit of residents utilizing liquid narcotic medication to ensure that no other residents on liquid medications were affected by this deficient practice. Done on 3/18/15. <p>To prevent recurrence:</p> <ul style="list-style-type: none"> · Pharmacy and pharmacy consultant notified and educated on policy and procedure for medication labels. · All nurses will be 	

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F 441 SS=D Bldg. 00	<p>liquid medication on the label.</p> <p>In review of the corresponding "Controlled Substance Record" associated with the same bottle of hydrocodone with acetaminophen 7.5/325 mg, identified as dispensed on 3-12-15, it indicated 10 doses of this medication had already been provided to Resident #G by 5 different nurses, RN #4, LPN #5, RN #6, RN #7 and LPN #8 from the bottle.</p> <p>RN #4 then contacted the resident's attending physician to inform her of the issue and received a one time order to administer the same dose in pill form until the pharmacy could rectify the labeling issue.</p> <p>This Federal tag relates to Complaint IN00169655.</p> <p>3.1-25(k)(4)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>		<p>in-services on or before 3/31/15 on the policy and procedure for Medication Labels.</p> <ul style="list-style-type: none"> DON or Designee will observe 1 med pass daily to monitor for medication errors including Labels. The DON or Designee will monitor compliance using the QA Tool titled "Medication Error Review" daily X30 days, weekly X4, monthly X3, and quarterly thereafter. This QA Tool will be started on or before 4/1/15. <p><i>Attachments: Medication Labels Policy and Procedure (5-A), QA Tool "Medication ErrorReview" (5-B) .</i></p>	

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	<p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure facility staff administer medications to residents in a sanitary manner, including, but not limited to 1 of 10 residents observed during 1 of 3 medication passes with 4 nursing staff. This deficient practice has the potential to expose a resident to harmful pathogens. (Resident</p>	F 441	F441 INFECTION CONTROL It is the policy of this facility to not touch medications with hands. To correct this deficiency: · DON and Administrator notified on 3/18/15 of medication touched with bare hands during med pass. · DON provided immediate education to LPN #9 regarding the Medication Administration ProcedureAll	04/01/2015

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	<p>#F)</p> <p>Findings include:</p> <p>In a medication pass observation on 3-18-15 at 1:42 p.m. with LPN #9 for Resident #F, she was observed to obtain a medication packet containing one capsule of gabapentin 600 mg. She was observed to remove the capsule with bare, ungloved hands and empty the contents of the capsule into the medicine cup of applesauce.</p> <p>Upon completion of administering the medications to the resident, LPN #9 indicated she should have worn gloves to empty the capsule into the applesauce.</p> <p>On 3-19-15 at 8:45 a.m., the DON provided a copy of a policy/procedure entitled, "Medication Administration." This document was dated 10-4-12 and was identified as the current policy/procedure utilized by the facility. It indicated, "...Do not touch tablets with hands...Altering of medication: Ensure that there is a physician's order stating it is acceptable to crush tablets or open medication capsules and give with food substance. If a medication should not be crushed or altered contact physician for an alternate medication or liquid equivalent..."</p>		<p>residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected: · LPN #9 immediately educated to not touch medication with bare hands during med pass. To prevent recurrence: · All nurses will be in-serviced on or before 3/31/15 on the policy and procedure for Medication Administration, including not touching tablets with bare hands. · DON or Designee will do a daily audit of each MAR in the facility to ensure that the "DO NOT CRUSH" list is on the MAR. This will be included in the "Medication Error Review" · DON or Designee will observe 1 med pass daily to monitor for medication errors including DO NOT CRUSH medications and proper hand hygiene. · The DON or Designee will monitor compliance using the QA Tool titled "Medication Error Review" daily X30 days, weekly X4, monthly X3, and quarterly thereafter. This QA Tool will be started on or before 4/1/15. It is the policy of this facility that there is a physician's order stating is acceptable to crush tablets or open medication tablets when appropriate and to contact physician for an alternate medication when not appropriate. To correct this deficiency: · DON and Administrator notified on 3/18/15 of medication error with crushed tablet of Diltiazem. Resident is able to take</p>	

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