

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2012
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NAME OF PROVIDER OR SUPPLIER MORNINGSIDE NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 18325 BAILEY AVE SOUTH BEND, IN 46637
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F000000	<p>This visit was for the Investigation of Complaint IN00115698.</p> <p>Complaint IN00115698-Substantiated. Federal/state deficiency related to the allegation cited at F431.</p> <p>Survey date: November 13, 2012</p> <p>Facility number: 004732 Provider number: 155752 AIM number: 200808300</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census payor type: Medicare: 1 Medicaid: 26 Other: 7 Total: 34</p> <p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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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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F000431 SS=D	<p>Quality review 11/14/12 by Suzanne Williams, RN</p> <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 quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record</p>	F000431	<u>What corrective action(s) will be accomplished for those residents</u>	12/07/2012			

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	<p>review, and interview, the facility failed to follow their policy for accounting of controlled medication, related to failure to count narcotic pain medications every shift, for 1 of 3 residents reviewed for narcotic pain medications in the sample of 4. This deficient practice had the potential to affect 6 of 6 residents with physician orders for narcotic pain medications. (Resident #D)</p> <p>Findings include:</p> <p>On 11/13/12 at 11:40 a.m., LPN #1 was observed completing a narcotic count of medications for residents on the South unit. There were two containers of Norco 5/325 milligram tablets for Resident #D locked in the South Unit medication cart. One container had a total of (110) Norco pills. The container of the pills was delivered from an out of state pharmacy on 11/9/12. The label indicated the medication was filled on 11/5/12 in another state with a total of (127) pills. The second container of Norco was filled on 11/5/12 and delivered to the facility on 11/9/12 with a total of (233) pills. There were (233) Norco pills in this container. The second container had a piece of tape wrapped around</p>		<p><u>found to be have been affected by the deficient practice.</u> The physician and family were notified of the deficient practice. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> A complete audit will be conducted by the Director of Nursing or designee of all narcotic count logs and both med carts to ensure that all currently ordered narcotics are counted q shift by the oncoming and outgoing nurse. (Documented on the narcotic count weekly audit sheet). See attachment A . Any negative findings of the audit will be investigated further to ensure compliance. This will be complete by 11/30/12. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</u> The facility pharmacy policy titled "Managing Controlled Medications" has been reviewed and updated. (Refer to Omicare, Inc. policy 5.4 "procedures for inventory control of controlled substances". All licensed nurses will be in-serviced on the updated policy for managing controlled medications on 11/23/12. (See attachment C). New nursing staff orientation will include hands on training for narcotic medication administration and record-keeping. Currently there is one family that utilizes a mail</p>		

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	<p>the lid. The date of 11/9/12, two Nurses signatures, and the number (233) were hand written on the tape. LPN #1 removed the tape from around the lid and removed the lid. There was no seal on the bottle when the lid was opened. The LPN counted the number of Norco pills in this container and verified there were (233) pills present.</p> <p>There were two separate sign out sheets for Resident #D's Norco pills. The first sheet was initiated on 11/9/12 and indicated a total of (127) pills were in the container on that date. Four doses were signed out each day with the number of remaining pills listed after each dose was signed out. The second sheet was also initiated on 11/9/12 and indicated a total of (233) pills were delivered on that date. There were no doses signed out on the sheet for the bottle of 233 pills. There was no documentation of the staff counting the (233) Norco pills each shift on the second sheet since 11/9/12.</p> <p>When interviewed at this time, LPN #1 indicated she was working when the above two containers of the Norco were delivered to the facility on 11/9/12. The LPN indicated she and another Nurse counted the</p>		<p>order pharmaceutical service. In particular Medco dispenses medications in 180 day supply increments to keep costs low. For resident's to utilize this service, the prescribing physician is required to write scripts for a 180 day supply. The entire 180 day supply is dispensed to the facility at one time. Per Medco, a prescribing physician can write for 180 days, to be dispensed in 30 day increments, However this will increase the cost considerably to the POA. It is the resident/POA choice to select a pharmacy of their choosing and/or refuse to comply with this recommendation. The Director of Nursing or designated agent will audit the narcotic count logs and both medication carts weekly x 4 weeks ending 12/21/12 to ensure ongoing compliance with the updated controlled substance management policy. <u>How will the corrective actions be monitored to ensure the deficient practice will not recur</u> Subsequent audits will occur monthly to ensure a minimum of 99% compliance for six months. The DON will forward the audit results to the Administrator for review. The Administrator will track and trend the data results and will submit the results quarterly at the QA Committee meeting for further review and recommendation. The Q/A Committee will determine the need for audits beyond six</p>		

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	<p>number of pills in each of the two containers on 11/9/12 and then wrapped a piece of tape with their signatures and the date of 11/9/12 around the lid of the bottle of the (233) Norco pills. The LPN indicated no Norco had been used from the bottle of (233) pills. The LPN also indicated nurses were not counting the number of pills in the bottle they taped up at the change of each shift since they felt it was sealed with the tape.</p> <p>The record for Resident #D was reviewed on 11/13/12 at 9:45 a.m. The resident's diagnoses included, but were not limited to, renal failure, diabetes mellitus, dementia, behavioral disturbances, and coronary artery disease.</p> <p>Review of the 11/2012 Physician orders indicated there was an order for the resident to receive Norco (a narcotic pain medication) 5/325 milligrams every 6 hours.</p> <p>The facility pharmacy policy titled "Managing Controlled Medications" was reviewed on 11/13/12 at 12:30 p.m. The policy was dated 01/01/05. The Director of Nursing provided the policy and indicated the policy was current. The policy</p>		<p>months of compliance for greater than a 1% error margin. The anticipated date of completion is 12/7/12.</p>				

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	<p>indicated at the end of each shift the Nurse leaving and the Nurse arriving were to check narcotics for an accurate count. The policy also indicated a record is to be utilized for each shift count.</p> <p>When interviewed on 11/13/12 at 1:30 p.m., the Director of Nursing indicated the the two bottles of Norco for Resident #D were not delivered by the facility contracted Pharmacy. The Director of Nursing indicated the medications were delivered by a mail order pharmacy and they shipped two containers of Norco for a total of (360) Norco pills all on 11/9/12. The Director of Nursing indicated the Nurses placed a piece of tape around the lid of the bottle of (233) pills and they felt this "sealed" the medications, and they were not counted at each shift change. The Director of Nursing indicated Nurses were signing out verification of shift to shift counts for the bottle of the (127) Norco tablets as per the facility pharmacy policy but not for the bottle containing the other 233 pills.</p> <p>This federal tag relates to Complaint IN00115698.</p> <p>3.1-25(e)(2)</p>						

