STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	612 EAST 11TH STREET RUSHVILLE, IN46173

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for the Recertification and State Licensure Survey. Survey dates: October 11, 12, 13, 14, and 17, 2011 Facility number: 000018 Provider number: 155053 AIM number: 100273930 Survey team: Barbara Gray, RN-TC Sharon Lasher, RN Leslie Parrett, RN Angel Tomlinson, RN Vallie Cassette, RN Census bed type: SNF: 8 NF: 4 SNF/NF: 65 Residential: 16 Total: 93 Census payor type: Medicare: 12 Medicaid: 54 Other: 27 Total: 93 Stage 2 sample 40 These deficiencies reflect state	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	findings cited in accordance with 410 IAC 16.2. Quality review completed on October 19, 2011 by Bev Faulkner, RN			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to receive a physicians order for the use and care of an indwelling urinary (Foley) catheter for 1 of 2 residents who met the criteria for a catheter. (Resident #127) Findings include: On 10/13/11 at 9:23 A.M., Resident #127 was observed seated in the therapy room, placing pegs in a board. Resident #127 had a catheter bag inside a cloth bag attached to her chair. Resident #127's record was reviewed on 10/13/11 at 9:24 A.M.	F0315	A Physician's order was obtained for the use and care of a Foley catheter for resident #127.All residents with a Foley catheter have the potential to be affected by this deficient practice. Residents that have a Foley catheter upon admission and current residents that receive a Foley catheter will have a QA audit tool used to ensure they have appropriate orders for the catheter and it's care.Nursing staff inservice to be held 11.7.2011 re-educate staff on the facilities Policy and Procedure for Foley catheters and their care and Physicians orders.Corrective action will be QA monitored using the Urinary catheter audit tool. This tool will be used by the DON or Designee daily x 1 week, then weekly x 4 weeks, then	11/09/2011

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	A local hospital note for Resident #127, dated 10/3/11 at 3:52 P.M., indicated the following: Past Medical History - Significant for - Renal insufficiency with history of hydronephrosis in the right ureter. Plan - We are going to repeat an ultrasound of her renal system and check it for the hydronephrosis. If it is still present, we will have a Lasix renal scan ordered. We will work on extended care facility placement and consult with her physician. A local hospital note for Resident #127, dated 10/5/11 at 1:31 P.M., indicated the following: "Has had improvement in her sodium. Her renal ultrasound showed improvement in her hydronephrosis. We are going to be sure that the Lasix renal scan was done, if not, one will need to be ordered. We are going to set her up with an endocrinologist regarding her hyperthyroid. She is due to go to a nursing home and will be ready to go tomorrow. The rest of the work-up can be done as an outpatient if necessary." A physicians order for resident #127 printed on 10/6/11, signed by LPN #1 on 10/6/11, and signed by the physician on 10/11/11, indicated the		monthly x 6 months to ensure all residents with a Foley catheter have a Physician's order for the use and care of a catheter. This process will be monitored using the Quality Improvement tool- Urinary Catheter Review. The results will be reviewed by the Quality Assurance Committee and any recommendations made will be implemented.	

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	following: Diagnoses - unspecified disorder of the kidney and ureter, hydronephrosis, malignant neoplasm of uterus part unspecified, hypertension, and history of urinary tract infection. A Genitourinary assessment for Resident #127, dated 10/6/11, indicated the following: The resident has an indwelling catheter. The catheter is patent and draining urine properly. The resident's bladder is non-distended. A physicians Admission History and Physical for Resident #127, dated 10/11/11, at 12:47 P.M., indicated the following: Active problems - Needs follow-up for hyponatremia. The resident has urinary retention, hyponatremia, and hypertension. A catheter care plan for resident #127, dated 10/6/11, indicated the following: Problem - The resident requires the use of a catheter as demonstrated by clinical condition listed on catheter assessment. The resident has a diagnoses of renal insufficiency with a history of hydronephrosis in the right upper ureter. Goal - Catheter will be maintained per plan of care daily and the resident will remain free from			

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	catheter related complications daily such as leakage, bacteremia, pyelonephritis, etc... Interventions - Assess for cause of leakage such as irritation due to a large balloon, excessive catheter diameter, fecal impaction, and/or improper catheter position. Change catheter as indicated per physicians order. Document any catheter related complications in the Electronic Medical Record (EMR) and update the physician as needed. Educate the resident and responsible party of the risk and benefits. Encourage fluid intake and record outputs each shift on the output record. Establish frequency of drainage bag changes and keep the bag covered. Maintain the urinary drainage bag below bladder level to facilitate flow of urine. Monitor fluid intakes and offer extra water between meals to increase free flow water hydration. Monitor for changes in level of consciousness. An interview with LPN # 2 on 10/13/11 at 10:23 A.M., indicated there were no physicians orders for Resident #127's catheter or catheter care. LPN # 2 indicated no information was available on Resident #127's medication or treatment record related to a catheter or catheter care.			

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	The most recent Catheter Use (Indwelling) procedure provided by the Director of Nursing on 10/14/11 at 2:00 P.M., indicated the following: ...If assessment determines that the indwelling catheter is medically justified a physician order will be obtained. The physician order will contain the size of catheter and balloon, frequency of changing, and indicate the clinical condition/medical diagnoses for continued use. 3.1-41(a)(1)			

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F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation and interview, the facility failed to provide a safe environment that protected residents from potential injury. The side rails for 1 of 1 resident (Resident # 2) with full length side rails were not adequately checked and monitored to ensure proper fit and unoccupied resident rooms under renovation were not locked to ensure 5 of 5 wandering residents did not have access to tools. (Residents #34, #65, #82, #126, #127) Findings include: 1.) On 10/13/11 at 10:00 a.m., during observation of Resident # 2, he was lying in his bed with his legs thrashing up and down. The Resident had slid down in the bed with his head just above the middle of the bed. The seizure pad on the upper portion of the side rail was pulled loose with the side rail showing. There was approximately a 6-8 inch gap between the footboard and the end of the side	F0323	1.) Resident #2 was placed in a low bed without side rails and mats were placed on easch side of the bed. 2.) Maintenance staff removed the cart and tools from the unoccupied rooms and placed them in a secure location.1.) Resident's with side rails will have the rails measured to ensure no other rails exceed the recommended safety guidelines. Prior to initiating the use of side rails, the rails will be measured prior to placement on the bed.2.) Maintenance cart and tools will be used under supervision and kept in a secure location when not in use. 1.) All staff to be inserviced on side rails measurement FDA guidelines and entrapment risks.2.) Maintenance staff will be re-educated on the facility policy and procedure for Maintenance Safety Goals.1.) Corrective action will be QA monitored using the Side Rail audit tool. This tool will be used by Maintenance Staff or Designee daily x 1 week, weekly x 4 weeks, then monthly x 6 months to ensure all side rails meet the FDA measurement guidelines. This process will be monitored using the Quality Improvement tool- Side Rail Review. The results will be reviewed by the Quality Assurance Committee and any	11/09/2011

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	rail. On 10/13/11 at 10:30 a.m., interview with the Assistant Maintenance Supervisor indicated that he had adjusted the gap at the foot of the bed. The current gap from the end of the bed rail to the foot board measures 3 & 5/8 inches. 10/14/11 at 2:40 p.m., interview with the Maintenance Supervisor indicated that the side rails do not fit well on the bed, the bed frame has a curve where the side rails fit. He indicated that over time with movement of the resident, the rails will shorten and leave a gap at the head or foot of the bed. He also indicated the facility needed to get better fitting bed rails for the type of bed frames that are in use. 10/13/11 at 3 p.m., review of Care Plan, dated 3/6/09, for side rails included: Need for 2 full length side rails, padded, up on each side of the bed to provide tactile bed boundaries for resident with sensory deficit and poor muscle coordination to prevent accidental rollout and has seizures. Will display no ill effects related to side rail use. Complete side rail screen initially, quarterly and PRN.		recommendations made will be implemented. NOTE: There are no FDA guidelines mandated for Zone 6 (foot/head board to end of rail- area of deficient practice noted.)2.) Corrective action will be QA monitored using the Maintenance Safety Review audit tool. This tool will be used by the Maintenance Supervisor or Designee daily x 1 week, then weekly x 4 weeks, then monthly x 6 months to ensure all Maintenance tools and cart are used under supervision and stored in a secure location. This process will be monitored using the Quality Improvement tool-Maintenance Safety Review. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.	

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	Ensure proper body alignment maintained in bed and that resident is not placed too close to either side of bed. Ensure when resident is up in Broda chair that thigh supports are in place for positioning and seizure precautions. Notify MD of any condition changes. Discharge Plan (for activities) Long term placement planned due to he needs 24 hour nursing care. All of his needs will be met while here. Assist with obtaining any consult needed to meet his needs and provide the care. Meet his ADL needs daily. Notify SS of any mood problems or changes in condition. Observe for special needs due to his cognitive status. Visit one on one for social interactions and anticipate his needs. Review of the side rail policy provided on 10/14/11 at 2:00 p.m., by the Director of Nursing indicated: "...Side Rail Assessment Procedure: A. PURPOSE 1. To ensure appropriate use of side rails. B. PROCEDURE 5. Determine the safety of side rail(s) used..."			

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	2.) On 10/11/11 at 3:21 P.M., unoccupied rooms #23 and #24 were observed unlocked with signs on each door that read "Please do not enter repairs in progress." No staff were present in those rooms. Room #23 had a hammer, caulking, tape measure, and drill on the night stand. Room #24 had a cart with numerous items including nails, screws, screwdrivers, caulking, drills, and scrapers. An interview with LPN #1 on 10/11/11 at 3:25 P.M., indicated there were confused residents living in the hallway where Rooms #23 and #24 were located. LPN #1 indicated Maintenance had been working on the air conditioners in Rooms #23 and #24. LPN #1 indicated the doors could not be locked for rooms #23 and #24. An interview with the Administrator on 10/11/11 at 3:45 P.M., indicated 5 confused residents had the potential to wander into Room #23 and #24. The Administrator identified residents #34, #65, #82, #126, and #127, as the residents potentially at risk. 3.1-45(a)(1) 3.1-45(a)(2)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to provide adequate behavioral monitoring before beginning antipsychotic medication (Zyprexa) for 1 of 10 residents who met the criteria for unnecessary drugs in the Stage 2 sample of 40. (Resident # 100) Findings include:	F0329	Resident #100 placed on a Behavior Monitoring Record (BMR). This record indicates Zyprexa is appropriate and effective for her diagnosis and her behaviors. Non-pharmacological interventions have been put into place. Facility Psych services consultant (Vericare) to evaluate and treat this resident. Residents receiving antipsychotics will be reviewed for appropriate	11/09/2011

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	Review of the clinical record for Resident # 100 on 10/13/11 at 9:15 a.m., included on 10/2/11 at 10:42 p.m., a behavior note indicated the resident was caught talking to someone and was trying to talk them into letting her outside. A 10/3/11, 11:48 p.m. nursing note indicated the resident became very agitated over the wander guard on her ankle. She demanded facility staff take it off or give her scissors to cut it off. If staff didn't let her take it off she would break her own leg, and began cursing at the staff. The resident threw her walker and slammed doors. She demanded to know who put her in this hell hole. The wander guard was removed from the resident's leg and placed on the resident's walker. Review of physician orders on 10/13/11 at 9:15 a.m., indicated on 10/3/11 at 11:56 p.m. 1.) Received order for Zyprexa 5 mg one time. 2.) Contact Physician to continue Zyprexa 5 mg. On 10/4/11 at 3:14 p.m., faxed physician's order indicated "Would you like to try Zyprexa 5 mg every hs 1 tab po?" Return fax on 10/5/11 at 11:30 a.m., indicated "ok"		diagnosis. Non-pharmacological interventions will be attempted prior to initiation on new orders for antipsychotic medications. Residents with new behaviors will be started on a 7 day behavior monitoring plan, a BMR will be initiated and non-pharmacological interventions will be attempted. Vericare will be notified as needed for further evaluation and treatment. All antipsychotic medications will be monitored quarterly by the Behavior Management Team and Pharmacist to ensure gradual dose reductions are being atttempted. No residents will be started on antipsychotic drugs prior to Social Services or Behavior committee reviewing for necessity. Nursting staff inservice to be held on 11.7.2011 to re-educate staff on the facility policy and procedures for Psychotropic medication use, non-pharmacological interventions, 7 Day behavior monitoring and pharmacy gradual dose reduction. Corrective action will be QA monitored using the Behavior and Antipsychotic Medication Review tool. This tool will be used by the Social Service Director or designee daily x 1 week, weekly x 4 weeks, then monthly x 6 months to ensure all residents who exhibit behaviors have non-pharmacological interventions attempted prior to the initiation of an antipsychotic medication, 7 day behavior	

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	A physician order, dated 10/12/11 at 4:40 p.m., indicated received diagnosis of dementia with aggressive behavior noted. Resident's son is aware. 10/14/11 at 2:05 p.m., interview with the Unit Manager indicated no 7 day behavior tracking log was completed. Review of a document provided by the Director of Nursing on 10/14/11 at 2:00 p.m. indicated: "Manual: Nursing Policy & Procedure Manual-Subject: PSYCHOTROPIC MEDICATION USE: Purpose: To ensure that medication regimen helps promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or representative(s) in collaboration with the attending physician/psychiatrist and facility staff; each resident receives only those medications, in doses and for the duration clinically indicated decline or to treat the resident's assessed condition(s); non-pharmacological interventions are considered and used when indicated, instead of, or in addition to, medication; Clinically significant adverse consequences are minimized; and the potential		monitoring started and an appropriate diagnosis present. This process will be monitored using the Quality Improvement tool-Behavior and Antipsychotic Medication review. The results will be reviewed by the Quality Assurance Committe and any recommendations made will be implemented.	

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	contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate. Psychotropic medications will only be used when medically indicated to treat a specific condition. Gradual Dose Reductions (GDR) will be attempted, unless clinically contraindicated, in an effort to discontinue these drugs. Ongoing monitoring will be in place to asses risks vs benefits of continued medication use and psychotropic medications will not be used as a restraint. Procedure: 1. The facility will assure that medication therapy is based upon an adequate indication for use by documenting the supporting diagnosis/indication of use at the time the order for psychotropic medication is obtained/received. 2. On-going monitoring of target behaviors will be documented as they occur in the clinical record along with the interventions used to reduce and the			

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	results." 3.1-48(a)(3)			
F0356 SS=B	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to post	F0356	Posted staffing numbers were corrected to reflect the number of licensed staff working as direct	11/09/2011

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 612 EAST 11TH STREET RUSHVILLE, IN46173	

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	nurse staffing information, and when staff did post it they failed to ensure it only reflected the licensed nursing staff that were directly responsible for resident care, for 1 of 4 Survey days. Further, the posting did not have the facility name. Findings include: During the 10/11/11 9:45 a.m. initial facility tour, the licensed nurse staffing information was not observed posted. After requesting the location of the staffing information from LPN # 2 at 10/11/11 9:45 a.m., the facility posted the information on the door of the managerial nursing staff's office. On 10/11/11 at 12:55 p.m., the posting was reviewed with the Director of Nurses (DON). The posting indicated there were four Registered Nurses working on the 10/11/11 day shift. Also the name of the facility was not observed noted on the posting. During this review, the DON indicated the Registered Nurses noted were not responsible for resident care as indicated by the posting. On 10/14/11 at 1:37 P.M., the DON		care staff. The corrections were reposted. NOTE: Facility name (Miller's Merry Manor) was present on the form. No residents were affected by the deficient practice. Direct care licensed nursing staff numbers posted daily. Staffing coordinator and back up staff re-educated on facility policy and procedure for Posting of Daily Nurse Staffing Information.Corrective action will be QA monitored using the Daily Nurse Staffing Form Review tool. This tool will be used by the DON or Designee daily x 1 week, weekly x 4 weeks, then monthly x 6 months to ensure all posting numbers are accurate. This process will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.	

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	indicated the staff who completed the 10/11/11 staffing had mistakenly added the Registered Nurses in house to the nursing staff posting and those Registered Nurses were not providing direct resident care on that day. 3.1-13(a)			
F0425 SS=D	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. Based on observation and record	F0425	Expired eye drops were disposed	11/09/2011

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	review, the facility failed to dispose of 2 expired Ophthalmic solutions found in 1 of 3 medication carts reviewed for expired medications. Findings include: Observation of the West Unit medication cart on 10/14/11, indicated Patenol Ophthalmic solution expired on 10/11/11 and Pred-Forte Ophthalmic solution expired on 10/12/11. On 10/14/11 at 2:30 p.m., the Unit Director of the West Unit provided a copy of a policy titled "Expiration Dates of Medications ...Miscellaneous Products... Ophthalmic/nasal solutions - 3 months after opening..." 3.1-25(o)		of and new bottles ordered. No residents were negatively affected by this deficient practice.Medications in the medication cart were audited for expired dates. Medication carts to be audited weekly for expiration dates and disposed of and re-ordered as needed.Nursing staff inservice to be held 11.7.11 to re-educate staff on the facility policy and procedure for Expired Medications and Medication Administration Procedure.Corrective action will be QA monitored using the Daily Nurse Staffing Form Review tool. This tool will be used by the DON or Designee daily x 1 week, weekly x 4 weeks, then monthly x 6 months to ensure correct direct care licensed staff hours are posted. This process will be monitored using the Quality Improvement tool-Daily Nurse Staffing Form Review. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.	

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F0431 SS=D	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. 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. 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. 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. Based on observation, staff interview, and record review, the facility failed to ensure medications were labeled with resident's names,and directions for administration, in 1 of 2 medication storage rooms, and in 2 of 3 medication carts investigated.	F0431	Unlabeled medications were disposed of properly. No residents experienced a negative effect from this deficient practice.An audit of each medication/ treatment cart and medication refridgerator was completed to ensure all medications are labeled appropriately. Medication/	11/09/2011

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	Findings include: During tour of the East nurses station medication storage room on 10/13/11 at 3:40 p.m., with LPN #1, two vials of insulin were observed in the refrigerator. Both lacked complete labeling and did not include the directions for administration or the resident's name. There was a vial of Humulin 70/30, and LPN #1 indicated it had been used by a resident who had been discharged from the facility. The 70/30 vial did not have a label that included directions for administration. The second bottle was Novolog and noted a resident's name, but did not have directions for administration. LPN #1 removed both from the refrigerator indicating they needed to be discarded. 3.1-25(j) 3.1-25(k)(1) 3.1-25(k)(5)		treatment carts and medication refidgerators will be audited weekly to ensure all medications are labeled appropriately.Nursing staff inservice to be held 11.7.2011 to re-educate staff on the policy and procedure for Medication Administration and proper labeling of medications.Corrective action will be QA monitored using the Medication Cart Audit Review tool. This tool will be used by the DON or Designee daily x 1 week, weekly x 4 weeks and monthly x 6 months to ensure all medications are labeled properly. This process will be monitored using the Quality Improvement tool-Medication Cart Audit Review. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.	

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