

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2013
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NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038
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F000000	<p>This visit was for the Investigation of Complaint IN00126343.</p> <p>Complaint: IN00126343 Substantiated. Federal/State deficiencies related to the allegation are cited at F282, F333, F431 and F514.</p> <p>Survey dates: April 1 & 3, 2013</p> <p>Facility Number: 012466 Provider Number: 155786 AIM Number: 201014060</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 33 SNF/NF: 116 Total: 149</p> <p>Census Payor Type: Medicare: 33 Medicaid: 95 Other: 21 Total: 149</p> <p>Sample: 4 Supplemental Sample: 10</p>	F000000	F0000April 11, 2013 Please find the attached plan of correction for the Complaint Survey #IN00126343 performed on April 1 and April 3, 2013. The provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a post survey revisit.	
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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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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 10, 2013 by Brenda Meredith, R.N.</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 observation, record review and interview, the facility failed to ensure a resident's physician order and plan of care were followed for 1 of 4 sampled residents. (Resident "A")</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 04-01-13 at 9:25 a.m. Diagnoses Included but were not limited to a history of urinary tract infection, depressive disorder, hypertension, syncope and collapse, atrial fibrillation, and osteoporosis. These diagnoses remained current at the time of the record review.</p> <p>The resident was discharged from a local area hospital on 02-04-13, with physician orders which included "Cymbalta [a medication used in the treatment of depression] daily. Pt. [patient] takes a total of 90 mg [milligrams] daily."</p> <p>At the time the resident was admitted to the facility on 02-04-13, the</p>	F000282	<p>F 0282 1. What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice</p> <p>-Resident "A" physician was notified of medication and resident is receiving medication as prescribed by physician. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken - All residents have the potential to be affected. - All licensed nurses were given a skills validation with return demonstration by DNS/Designee for medication administration. - All licensed nurses were in-serviced by Director of Nursing Services on April 8, 2013, regarding 5 Rights of Medication Administration. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur - All licensed nurses were in-serviced by Director of Nursing Services on April 8, 2013, regarding 5 Rights of Medication Administration. - DNS/Designee audited licensed Nurse #13 and #14 using the</p>	04/19/2013	

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	<p>physician orders were transcribed by the facility nurse on the February 2013 re-write, as "Cymbalta SR [sustained release] 90 mg one by mouth QD [every day]."</p> <p>Review of the "Nursing Spectrum Drug handbook," on 04-01-13 at 3:30 p.m., indicated this medication is supplied in 20 mg, 30 mg and 60 mg capsules.</p> <p>Review of the resident's Plan of Care, dated 02-15-13 indicated the resident "is at risk for s/s [signs and symptoms] of depression [sad facial expression, withdrawal <sic>, decreased appetite, tearfulness, insomnia, verbalization of depression, etc.]. Resident has a dx. [diagnosis] of depression."</p> <p>The "goal" to this plan of care, with a target date of 07-02-13, indicated "resident will have no increase in symptoms of depression aeb [as evidence by] PHQ-9 [Patient Health Questionnaire - nine questions] score and observations of s/s of depression." Interventions included "allow resident to express feelings and frustrations: offer validation and support, encourage family support and involvement."</p> <p>The 02-19-13, Social Service note</p>		<p>medication pass CQI audit. -</p> <p>DNS/Designee will monitor residents' medication administration with the medication pass CQI to ensure all licensed Nurses administered resident medications as ordered. -</p> <p>Licensed staff not adhering to policy will receive education, disciplinary action up to and including termination.4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place. - To ensure compliance the DNS/Designee is responsible for Medication pass CQI for 2 nurses each shift weekly x4, bi weekly x1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. - If threshold of 100% is not achieved, an action plan will be developed to assure compliance.</p>	

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	<p>indicated the "score" of "18" on the PHQ-9 indicated "moderately severe depression."</p> <p>A review of the current physician re-write for March 2013, indicated "Cybalt 30 mg cap [capsule] take 3 capsules [90 mg] by mouth once daily Dx [diagnosis]: Depression."</p> <p>During an interview on 04-03-13 at 10:30 a.m., a concerned family member indicated, "I don't think [resident] is getting all of the medication for depression. [Resident] is different than before. I know the other day the nurse only gave [resident] one of the capsules, and I had to tell her, the prescription was for a total of 90 mg and she was only giving [resident] 30 mg when giving only one capsule."</p> <p>Interview on 04-03-13 at 10:40 a.m., the resident indicated "Yes I feel depressed, I think I just want to go home." During this interview, the resident remained expressionless and had a flat affect.</p> <p>Observation on 04-03-13 at 10:00 a.m., with Licensed Nurse employee #4 in attendance, provided the current bubble packs containing the resident's anti-depressant. The</p>						

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	<p>licensed nurse indicated the current medication packs contained 64 remaining capsules.</p> <p>The number of capsules delivered by the pharmacy totaled 210 capsules.</p> <p>Review of the February 2013, medication administration record indicated the resident received the medication on 23 days, for a total of 69 capsules administered, March 2013, medication administration record indicated the resident received the medication on 31 days, for a total of 93 capsules administered, and the April 2013, medication administration record indicated the resident received the medication on 3 days for a total of 9 capsules.</p> <p>Interview on 04-03-13 at 10:10 a.m., Licensed Nurse employee #4 indicated a concerned family member notified her on 04-02-13, that Licensed Nurse employee #13 had not given the resident the amount of medication as prescribed. Licensed Nurse employee #4 indicated she asked the family resident had not received the appropriate dosage and the family member indicated "yes, [name of Licensed Nurse employee #14], did not give [resident] the right amount of medication."</p>				

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	<p>The number of capsules the resident should have received from February 5, 2013 [the day after admission], through April 3, 2013 totaled 171 capsules, and therefore only 39 capsules should have remained to be dispensed and not the 64 as observed with Licensed Nurse employee #4.</p> <p>This Federal tag relates to Complaint IN00126343.</p> <p>3.1-35(g)(2)</p>			
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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident was free from significant medication errors, in that when the physician ordered a specific dosage of an antidepressant, the nursing staff failed to ensure the resident received the appropriate dosage for 1 of 4 sampled residents (Resident "A").</p> <p>Fiindings include:</p> <p>The record for Resident "A" was reviewed on 04-01-13 at 9:25 a.m.</p> <p>Diagnoses Included but were not limited to a history of urinary tract infection, depressive disorder, hypertension, syncope and collapse, atrial fibrillation, and osteoporosis.</p> <p>These diagnoses remained current at the time of the record review.</p> <p>The resident was discharged from a local area hospital on 02-04-13, with physician orders which included</p>	F000333	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> - Resident "A" physician was notified of medication error and resident is receiving medication as prescribed by physician. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken - All residents have the potential to be affected. - All licensed nurses were given skills validation with return demonstration by DNS/Designee for medication administration. - All licensed nurses were in-serviced by Director of Nursing Services on April 8, 2013, regarding 5 Rights of Medication Administration. 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur - All licensed nurses were in-serviced by Director of Nursing Services on April 8, 2013, regarding 5 Rights of Medication Administration. - DNS/Designee will monitor residents' medication administration with the medication pass CQI to ensure all licensed 	04/19/2013	

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	<p>"Cymbalta (a medication used in the treatment of depression), daily. Pt. (patient) takes a total of 90 mg (milligrams) daily."</p> <p>At the time the resident was admitted to the facility on 02-04-13, the physician orders were transcribed by the facility nurse on the February 2013 re-write, as "Cymbalta SR (sustained release) 90 mg one by mouth QD (every day)."</p> <p>Review of the "Initial Social History and Psychosocial Assessment," also indicated the resident took Cymbalta 90 mg by mouth daily for a diagnosis of depression.</p> <p>The Initial Minimum Data Set Assessment, dated 02-11-13, indicated the following in regard to the resident's "mood."</p> <p>"Little interest in doing things nearly every day, feeling down, depressed and tired and a poor appetite - nearly every day, has felt bad about self in the last 7 - 11 days, and had trouble concentrating in the last 2 - 6 days. Severe depression."</p>		<p>Nurses administered resident medications as ordered. -</p> <p>Licensed staff not adhering to policy will received education, disciplinary action up to and including termination.4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place - To ensure compliance, the DNS/Designee is responsible for Medication Pass CQI for 2 weeks each shift weekly x4, bi weekly x1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. - If threshold of 100% is not achieved, an action plan will be developed to assure compliance.</p>		

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	<p>The Assessment further indicated the resident is a "new admission to the Moving Forward Unit. Res. (resident) feels down, depressed and hopeless at time d/t (due to) resident medical and mental health condition."</p> <p>A decision was made to "proceed to care plan."</p> <p>Review of the resident's Plan of Care, dated 02-15-13 indicated the resident "is at risk for s/s (signs and symptoms) of depression (sad facial expression, withdrawal <sic>, decreased appetite, tearfulness, insomnia, verbalization of depression, etc.). Resident has a dx. (diagnosis) of depression."</p> <p>The 02-15-13 Social Service notation, indicated "SSA (social service assistant) spoke with resident and resident's POA (Power of Attorney) regarding resident's mood state. Resident scored an 18 on the PHQ-9 (Patient Health Questionnaire - nine questions). SSA offered (name of counseling services). Resident's</p>			

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	<p>POA did not want services at this time."</p> <p>The 02-19-13 Social Service note indicated the "score" of "18" on the PHQ-9 indicated "moderately severe depression."</p> <p>A review of the current physician re-write for March 2013, indicated "Cybalta 30 mg cap (capsule) take 3 capsules (90 mg) by mouth once daily Dx (diagnosis): Depression."</p> <p>Observation on 04-03-13 at 10:00 a.m., with Licensed Nurse employee #4 in attendance, provided the current bubble packs containing the resident's anti-depressant. The licensed nurse indicated the current medication packs contained 64 capsules.</p> <p>During an interview on 04-03-13 at 10:30 a.m., a concerned family member indicated, "I don't think (resident) is getting all of the medication for depression. (Resident) is different than before. I know the other day the nurse only</p>			

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	<p>gave (resident) one of the capsules, and I had to tell her, the prescription was for a total of 90 mg and she was only giving (resident) 30 mg when giving only one capsule."</p> <p>Interview on 04-03-13 at 10:40 a.m., the resident indicated "Yes I feel depressed, I think I just want to go home." During this interview, the resident remained expressionless and had a flat affect.</p> <p>A review of the "Delivery Manifest," from the local area pharmacy for February 2013 and March 2013 indicated the medication Cymbalta 30 mg - 42 capsules were delivered to the facility on 02-04-13, 02-16-13, 03-12-13 and 03-25-13, which totaled 168 capsules.</p> <p>The pharmacy manifest lacked information of a delivery between 02-16-13 and 03-12-13, however the Director of Nurses rechecked the medication cart and provided two additional bubble packets, which contained an additional 42 capsules, for the resident, with a delivery date</p>			

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	<p>of 02-28-12.</p> <p>The number of capsules delivered by the pharmacy was 210 capsules.</p> <p>Review of the February 2013 medication administration record indicated the resident received the medication on 23 days, for a total of 69 capsules administered, March 2013 medication administration record indicated the resident received the medication on 31 days, for a total of 93 capsules administered, and the April 2013 medication administration record indicated the resident received the medication on 3 days for a total of 9 capsules.</p> <p>Interview on 04-03-13 at 10:10 a.m., Licensed Nurse employee #4 indicated a concerned family member notified her on 04-02-13, that Licensed Nurse employee #13 had not given the resident the amount of medication as prescribed. Licensed Nurse employee #4 indicated she asked the family resident had not received the appropriate dosage and the family member indicated "yes,</p>				

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	<p>(name of Licensed Nurse employee #14), did not give (resident) the right amount of medication."</p> <p>The number of capsules the resident should have received from February 5, 2013 [the day after admission], through April 3, 2013 totaled 171 capsules, and therefore only 39 capsules should have remained to be dispensed and not the 64 as observed with Licensed Nurse employee #4.</p> <p>This Federal tag relates to Complaint IN00126343.</p> <p>3.1-48(c)(2)</p>			

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F000431 SS=D	<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, interview and record review the facility failed to ensure appropriate labeling of medications, in that when a resident</p>	F000431	F4311. What corrective action(s) will be accomplished for those residents found to have been affective by deficient practices - Residents	04/19/2013			

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	<p>had a change in medications, related to dosage, and time, the nursing staff failure to ensure appropriate labeling on the medication packet, and medication administration record for 1 of 4 sampled and 2 of 10 supplemental sampled residents (Residents "A", "K" and "G").</p> <p>Findings include :</p> <p>1. The record for Resident "A" was reviewed on 04-01-13 at 9:25 a.m. Diagnoses Included but were not limited to a history of urinary tract infection, depressive disorder, hypertension, syncope and collapse, atrial fibrillation, and osteoporosis. These diagnoses remained current at the time of the record review.</p> <p>The resident was discharged from a local area hospital with physician orders which included "Cymbalta [a medication used in the treatment of depression], daily. Pt. [patient] takes a total of 90 mg [milligrams] daily."</p> <p>At the time the resident was admitted to the facility on 02-04-13, the physician orders were transcribed by the facility nurse on the February 2013, re-write, as "Cymbalta SR [sustained release] 90 mg one by mouth QD [every day]."</p>		<p>"A,K, and G" physician was notified, and residents are receiving medications as prescribed by physician. - Residents "K" and "G" medications bubble packs now has a correct direction label on their bubble packs.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken - All residents have the potential to be affected. - All residents medications were audited by DNS/Designee to ensure bubble pack label matches the order in medication administration record. - All licensed nurses were given a skills validation with return demonstration by DNS/Designee for medication administration. - All licensed nurses were in-serviced by Director of Nursing Services on April 8, 2013, regarding Bubble pack label change and 5 Rights of Medication Administration.3. What measure will be put into place or what systemic changes will be made to ensure that deficient practice does not recur - All licensed nurses were in-serviced by Director of Nursing Services on April 8, 2013, regrind Bubble pack label change. - DNS/Designee audited Licensed Nurse #9, #10, #13 & #14 using the Medication pass CQI and to ensure that residents medication</p>				

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	<p>A review of the "Delivery Manifest," from the local area pharmacy for February 4, 2013, indicated 42 - 30 mg tablets were delivered to the facility.</p> <p>The nursing staff failed to correct the February 2013, medication administration record to reflect the resident to receive 3-30 mg tablets for a total dosage of 90 mg daily.</p> <p>2. During the medication pass observation on 04-03-13 at 12:35 p.m., Licensed Nurse employee #10 prepared medications for Resident "K." The Licensed Nurse prepared to dispense 4 medications to the resident, which included Lasix [a diuretic] and Depakote [an anticonvulsant]. The instructions on the bubble pack for the Lasix indicated, "Lasix 20 mg one, by mouth daily in the evening." The instructions on the bubble pack for the Depakote indicated "Depakote 500 mg one by mouth, two times a day."</p> <p>The Licensed Nurse indicated the Depakote "was recently change to three times a day."</p> <p>During the reconciliation of the</p>		<p>label matches medication administration record and physician order.</p> <ul style="list-style-type: none"> - DNS/Designee utilized Medication CQI to audit all licensed Nurses medication administration and to ensure correct bubble pack label. - DNS/Designee will monitor all new medication orders to ensure bubble pack has correct label and matches physician order. - Licensed staff not adhering to policy will receive education, disciplinary action up to and including termination. <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place - To ensure compliance the DNS/Designee is responsible for Medication Labeling CQI weekly x4, bi weekly x1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED.</p> <ul style="list-style-type: none"> - If threshold of 100% is not achieved, an action plan will be developed to assure compliance. 		

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	<p>medications on 04-03-13 at 1:00 p.m., the current physician re-write for April 2013, instructed the licensed nurse to provide the medication to the resident "in the evening," however in the section for the "hour" the medication was to be given indicated "1:00 p.m."</p> <p>Further review of the resident record indicated the Depakote was changed from two times a day to three times a day on 04-02-13.</p> <p>The bubble pack lacked a "direction change" label to alert the nursing staff of the recent change of the Depakote, or the need to correct the instructions for the Lasix.</p> <p>3. During the medication pass observation on 04-03-13 at 12:10 p.m., Resident "G" was provided Norco (a narcotic analgesic). Review of the bubble pack indicated "Norco 5-325 one by mouth every 6 hours as needed for pain." Licensed Nurse employee #9 indicated the medication was recently to a "scheduled" medication.</p> <p>During the reconciliation of the medications on 04-03-12 at 1:15 p.m., the resident had a physician order, dated 03-31-13, for Norco 5-325 one</p>						

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	<p>by mouth every 4 hours scheduled for pain.</p> <p>The bubble pack lacked a "direction change" label to alert the nursing staff of the recent change.</p> <p>This Federal tag relates to Complaint IN00126343.</p> <p>3.1-25(j)</p>				

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation and record review, the facility failed to ensure an accurate record for 1 of 4 sampled and 1 of 10 supplemental sampled residents. (Resident's "A" and "K")</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 04-01-13 at 9:25 a.m. Diagnoses Included but were not limited to a history of urinary tract infection, depressive disorder, hypertension, syncope and collapse, atrial fibrillation, and osteoporosis. These diagnoses remained current at the time of the record review.</p> <p>The resident was discharged from a local area hospital with physician orders which included "Cymbalta [a</p>	F000514	<p>F0514 1. What corrective action(s) will be accomplished for those residents found to have been affected by deficient practices. - Residents "A and K" physician was notified and resident is receiving medications prescribed by physician. - Resident "K" medication bubble pack now has a correct direction label on it.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken - All residents have the potential to be affected - DNS/Designee utilized Medication pass CQI to audit all licensed Nurses medication administration and to ensure medication time reflects accurately on medication administration record. - DNS/Designee will audit all charts</p>	04/19/2013			

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	<p>medication used in the treatment of depression], daily. Pt. [patient] takes a total of 90 mg [milligrams] daily."</p> <p>At the time the resident was admitted to the facility on 02-04-13, the physician orders were transcribed by the facility nurse on the February 2013, re-write as "Cymbalta SR [sustained release] 90 mg one by mouth QD [every day]."</p> <p>A review of the "Delivery Manifest," from the local area pharmacy for February 4, 2013, indicated 42 - 30 mg tablets were delivered to the facility.</p> <p>The nursing staff failed to correct the February 2013, medication administration record to reflect the resident to receive 3-30 mg tablets for a total dosage of 90 mg daily.</p> <p>2. During the medication pass observation on 04-03-13 at 12:35 p.m., Licensed Nurse employee #10 prepared medications for Resident "K." The Licensed Nurse prepared to dispense 4 medications to the resident, which included Lasix [a diuretic]. The instructions on the bubble pack instructed the nurse "Lasix 20 mg one, by mouth daily in the evening."</p>		<p>by 4/19/2013 to ensure medication time reflects accurate dispense time on the MAR. 3. What measure will be put into place or what systemic changes will be made to ensure that deficient practice does not recur</p> <ul style="list-style-type: none"> - All licensed nurses were in-serviced by Director of Nursing Services on April 8, 2013, regarding Bubble pack label change, 5 Rights of Medication Administration, and medication time on medication administration record. - Medication pass audit was done by DNS with Licensed Nurse #9, #10, #13, & #14. - DNS/Designee will monitor re-write to ensure medication time is correct on all re-write. - DNS/Designee will monitor all new medication orders to ensure bubble pack has correct label. - Licensed staff not adhering to policy will received education, disciplinary action up to and including termination. <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place - To ensure compliance, the DNS/Designee is responsible for Medication Labeling CQI weekly x4, bi weekly x1 month, and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen</p>		

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	<p>During the reconciliation of the medications, the current physician re-write for April 2013, instructed the licensed nurse to provide the medication to the resident "in the evening," however in the section for the "hour" the medication was to be given indicated "1:00 p.m."</p> <p>This Federal tag relates to Complaint IN00126343.</p> <p>3.1-50(a(2))</p>		<p>by the ED. - If threshold of 100% is not achieved, an action plan will be developed to assure compliance.</p>		