

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/18/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN 46970
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>This visit was in conjunction with the investigation of Compliant #IN00125814.</p> <p>Survey Dates: March 7, 8, 11, 12, 13, 14, 15, and 18, 2013</p> <p>Facility Number : 000014 Provider : 155039 AIM Number : 100288670</p> <p>Survey Team: Debora Kammeyer, RN-TL (3/7, 3/8, 3/11, 3/12, 3/13, 3/14, 3/18, 2013) Lora Swanson, RN (3/7, 3/8, 3/11, 3/12, 3/13, 3/14, 3/18, 2013) Julie Wagner, RN</p> <p>Census Bed Type: SNF/NF: 49 Total: 64</p> <p>Census Payor Type: Medicare: 15 Medicaid: 38 Private: 11 Other: 1 Total: 64</p>	F000000	Please accept this as our credible of compliance. We respectfully request consideration for paper compliance related to the following plan of correction.	

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 by Brenda Meredith, R.N. on March 28, 2013.</p>			

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure an ongoing activity program was provided to meet the needs of 1 of 3 residents who met the criteria. (Resident B)</p> <p>Finding includes:</p> <p>1. Resident B was admitted to the facility on 11/24/09, with diagnoses, including but not limited to, cerebral vascular accident with right side hemiparesis, diabetes mellitus, hypertension, and dysphasia with gastronomy tube placement.</p> <p>The most recent Minimum Data Set (MDS) assessment for Resident B, completed on 12/09/12, indicated the resident was severally impaired for decision making and cognitive skills, was totally dependent on staff for bed mobility, transferring, and wheelchair locomotion needs, was nonambulatory, and required total staff assistance for dressing and</p>	F000248	It is the intent of this facility to provide an on-going program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. Resident B continues to reside in the facility and suffered no negative consequences as a result of this finding. Resident B's activity plan has been reviewed and updated to reflect interests as indicated by family. Staff will be inserviced on the activities that resident's family indicates she has an interest in - e.g. books on tape, church programs on TV and group activities and a list given to staff weekly to ensure that these programs are in fact initiated. All residents have the potential to be affected by this deficient practice. 25% of activity care plans will be reviewed weekly x 4 weeks and then reviewed during quarterly HCP meetings to ensure that each resident has a program designed to meet his/her specific needs. Families of cognitively impaired residents will be contacted to ensure that their	04/12/2013			

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	<p>personal hygiene needs. The resident received tube feedings.</p> <p>On 03/07/13 from 2:00 P.M. - 3:00 P.M. and on 03/08/13 from 8:40 A.M. - 12:00 P.M. and from 1:00 P.M. - 3:30 P.M., Resident B was observed to be in her room in her bed. The resident was noted to have full, padded side rails elevated on both sides of her bed. At times the resident was noted to have pulled the sheet up and over her head.</p> <p>On 03/13/13 at 8:00 A.M., Resident B was observed in her bed, on her back awake. The resident had pulled her hospital gown up, exposing her abdomen and brief. She was noted to have a distressed look on her face and would rub her belly with her left hand. The unit manager was notified and she assessed the resident and repositioned her.</p> <p>On 03/13/13 at 9:10 A.M., Resident B was observed in her bed, covered up, on her back asleep.</p> <p>On 03/13/13 at 9:55 A.M., two staff members were observed to enter Resident B'S room, repositioned her by placing a pillow under her left side, and left the room.</p>		<p>interests meet their needs. Staff will be inserviced on 4/5/13 re the importance of following the activity plan of care for each resident. See Exhibit #1 The following QA tools will be utilized to determine if needs are being met? ACTIVITY 1:1 REVIEW - Exhibit #2 ACTIVITY PARTICIPATION REVIEW - Exhibit #3 These tools will be completed weekly x 4 and then monthly. Any discrepancies will be corrected and findings reported to the QA committee for monthly review. Activity Director Responsible Social Services will Monitor</p>		

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	<p>On 03/13/13 at 11:30 A.M. Resident B was heard "crying" in her room in her bed. A family member was in the room and indicated staff had just changed the resident's brief. He indicated he did not know why the resident was crying.</p> <p>On 03/14/13 at 8:45 A.M., Resident B was observed in her bed on her back, dressed in a pink shirt, awake. The television was not turned on in her room. She remained in her room, in her bed alternately sleeping and awake from 8:45 A.M. - 11:00 A.M. At 10:00 A.M., the nurse, who had administered medications to Resident B was noted to have turned the television on in the Resident B's room to a Gospel church service.</p> <p>On 03/14/13 at 2:00 P.M., Resident B was observed, dressed, awake, in the dining room, in a recliner, holding a bingo card underneath a blanket. No one was noted to be assisting Resident B to play Bingo, she was just watching other resident's play the game and was holding a Bingo card.</p> <p>On 03/15/13 at 9:10 A.M., Resident B was observed in bed, the siderails were elevated, the resident had a sheet over her head, and the television was off in the room.</p>			

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	<p>A Social Service Assessment, completed on 03/11/13 , indicated Resident B liked to come out to church activities and other activities, and was a passive participant.</p> <p>An Activity Assessment, completed on 12/11/12 , indicated the resident enjoyed books on tape, bingo, music, church, mostly gospel and easy listening music, church TV land game shows and family stuff, current events, religious activities outdoor activities, and pets. The assessment indicated the resident went to the following activities: music and special events, when in her room she watches TV and sometimes listens to her books on tape. She receives visits from volunteer.</p> <p>Review of the current health care plan regarding activities, revised on 12/04/12, indicated the following focus: "Residents family helped with her assessment due to her cognitive impairment. Residents family feels that it is important that resident listens to the kind of music that she likes, be around pets, does things with groups of people, does her favorite activities, spends time with her family, goes outside when the weather is good and practices her religious beliefs. They</p>			

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	<p>also feel it is somewhat important that she has books on tapes to listen to." The interventions included: "Provide resident with calendar of events for staff and family to look at. Invite, encourage and assist her out for activities, such as musical programs, Bingo, church services, Daisy the Dog and other pet visits and Fancy nails and assist her as needed to and from activities. Resident receives books on tapes staff have to turn on for her has TV in her room which stays on the church channel and she receives room visits twice a week from church volunteer."</p> <p>Review of the Activity participation record for Resident B indicated she attended 4 group activities from March 1 - 14, 2013. She also was documented as having activity non-attendance documentation and 4 One to One activities.</p> <p>Review of the Activity calendar for March 1 - 14, 2013, indicated there were 5 church services and 2 Bible study activities, 10 sensory group activities, 2 music programs, 2 Fancy nail activities, and 6 Bingo activities scheduled. There were also movies, linen clubs, sentimental reflections, cooking activities, and exercise activities on the schedule.</p>				

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	<p>On 03/18/13 at 11:30 A.M., interview with the Activity Director, indicated the computerized charting for activities did not designate exactly what the activity was the resident attended. She indicated Resident #39 went to a church service, an activity filling Easter eggs, Bingo, and a St Patrick's Day party. She also had 4 - 1:1 visit from a volunteer. The documentation from the volunteer for the 1:1 visits indicated on 3 of the 4 visits the resident kept her head covered and did not make eye contact. The Activity Director was uncertain how long the 1:1 visits lasted. The Activity Director indicated the "Non-attendance Activity documentation were documented for things such as chaplain visits, family visits, television on in the room, staff visits, to resident declined activity due to not feeling well. There was no documentation as to why the resident was left in her room during the morning hours and was not taken to group activities.</p> <p>The 03/13/13 , 1:1 visit, which had occurred in the morning of 03/13/13, indicated the resident kept her head covered and the volunteer left when the family came for a visit.</p>						

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	<p>Interview with Resident B's family, on 03/13/13 at 10:30 A.M., indicated she was concerned Resident B was not being "gotten up" and taken to activities. She indicated her mother had previously enjoyed being around people in groups and especially liked "Bingo." She indicated she had informed the staff of her mother's activity preferences in the past.</p> <p>3.1-33(a)</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 record review and interviews, the facility failed to follow a behavior management care plan for 1 of 1 residents who voiced an allegation of rudeness. (Resident #40) In addition, the facility also failed to ensure insulin orders and/or blood glucose monitoring orders were followed accurately for 2 of 10 residents reviewed for necessary medications. (Residents #2 and 25)</p> <p>Findings include:</p> <p>1. On 03/11/13 at 10:41 A.M., alert and oriented, Resident #40 indicated during the previous week, a CNA, employee #5, was very rude and "uppity" with him while she was providing care. He indicated the aide "cut him off" when he was trying to talk and told him, rudely "I'm talking." Resident #40 indicated he had told the charge nurse at the time, of the issue with CNA #5.</p> <p>Interview with Resident #40, on 03/12/13 at 10:26 A.M., indicated he had informed the nurse on duty at the</p>	F000282	<p>It is the intent of this facility that services provided or arranged by the facility will be provided by qualified persons in accordance with each residents plan of care. Residents #2, #25 and #40 remain in the facility. The residents suffered no negative consequences as a result of this finding. All residents have the potential to be affected by this deficient practice. The care plans for residents #2, #25 and #40 have all been reviewed and updated as needed. All residents receiving insulin have had all orders and care plans reviewed. An ALL STAFF INSERVICE will be held on 4/5/13 - Exhibit #1 Staff will be re-educated on: a. Care Plan Development and Review - Exhibit #4 b. Behavior Assessment and Management - Exhibit #5 c. Blood Glucose Monitoring - Exhibit #6 d. Medication Administration Procedure - Exhibit #7 e. Six Standards of Medication Administration - Exhibit #8 Monitoring to ensure care is provided per resident's plan of care will be done utilizing the QA tool CARE PLAN REVIEW - Exhibit #9. This tool will be completed weekly x 4 weeks by</p>	04/12/2013			

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	<p>time of the incident regarding CNA #5 and she had reported it to RN #6.</p> <p>Interview, on 03/12/13 at 10:30 A.M. , with RN #6, a unit supervisor, indicated she had been informed by Resident #40 last Friday about the incident. She indicated she spoke with both CNA's on duty at the time, CNA #5 and 7, and they indicated that there were no issues during care with Resident #40. RN #6 indicated Resident #40 told her CNA #5 yelled at him during care. RN #6 indicated she reported the allegation to the Director of Nursing and Social Services.</p> <p>Interview with the Administrator, on 03/12/13 at 10:32 A.M. indicated she was not aware of any incident regarding Resident #40 and CNA #5.</p> <p>Interview on 03/12/13 at 10:34 A.M., with Social Services Director, Employee #8, indicated she was informed of the incident on Monday because at the time of the incident she was gone. She indicated the DON was going to go talk to the resident about the issue. She indicated the DON gave her a "write up" on the incident.</p> <p>Review of the incident write up,</p>		<p>the DON/Designee, then monthly. Any identified issues will be addressed immediately and findings submitted to the QA committee for review monthly. Nursing ResponsibleDON/Designee will Monitor</p>		

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	<p>indicated the following: "On 03/08/2013, [Resident 40's name] was concerned regarding CNA yelling at him during the time of getting him up for supper. Talking with the two CNA's that were in the room with him they stated that each talked normally to him and he did no yelling at them. They had explained they could not get to him right away due to getting other residents up. He was agreeable with this."</p> <p>Interview with the Director of Nursing, on 03/12/13 at 10:42 A.M. indicated she was informed of the incident with Resident #40 and CNA #5 by RN #6 and she directed RN #6 to "write it up." Director of Nursing indicated Resident #40 makes false accusations against staff frequently and we have it care planned and there are always two staff members at all times when caring for the resident due to the false accusations. Resident #40 is inappropriate sexually with staff and when he is verbally told by staff "that's inappropriate" he gets mad and "makes up stories." The DON indicated since this is a repeated issue with Resident #40 she was following corporate instructions to make sure the incident is care planned and the care plan followed. DON indicated she feels she</p>						

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	<p>over-reports things.</p> <p>The clinical record for Resident #40 was reviewed on 03/12/13 and 10:20 A.M. Review of the nurse's notes and assessment section of the electronic clinical record indicated there was no documentation regarding the incident Resident #40 had reported or any follow up by staff regarding the incident.</p> <p>Review of the current Care Plans for Resident #40, current through 06/06/13 indicated the following: "[Resident's first name] at times will make degrading statements to staff and point out personal faults. He has also made inappropriate sexual comments to staff. He has also been known to tell mistruths about staff regarding care with the intent to get staff in trouble. Also at times he will become verbally abusive to other residents such as telling them to "shut up" when they are requesting help from staff - Goal [Resident's first name] will state less degrading and inappropriate things to staff and residents Interventions: 2 staff in room during care, remove resident from location as to prevent other resident's feelings from being hurt, ss [social services] to explain to resident how hurtful these comments to staff</p>						

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	<p>and residents can be. Ss to talk with resident and see if something is bothering resident to cause him to say those things to others, staff to document resident's mistruths about staff."</p> <p>Interview, on with the Social Services Director, on 03/12/13 at 10:43 A.M. and with the Director of Nursing, on 03/12/13 at 10:43 A.M., indicated neither staff had spoken directly with Resident #40 regarding the allegation he made on 03/08/13. The Social Service Director indicated she felt the nursing staff were taking care of the issue. The Director of Nursing indicated if Resident #40 was really upset regarding the issue, he would have come to her office and discussed the issue with her. Both staff members indicated RN #6 had already investigated the issue and the allegation was not considered an allegation of abuse but rather a mistruth by Resident #40.</p> <p>2. The clinical record for Resident #25 was reviewed on 03/08/13. The resident had diagnoses, including but not limited to, diabetes mellitus.</p> <p>The current physician's orders regarding the insulin and sliding scale</p>			

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	<p>insulin and parameter orders for Resident #25 indicated the following: Levemir 25 units sq (subcutaneous) at 9 pm and 20 units sq at 7 am, Novolog 100 /ml - inject 5 units sq 3x daily at 7a, 12p, and 5 p with meals for diabetes, sliding scale insulin orders Novolog inj (injection) 60 -80 subtract 2 units from meal coverage, 81 - 120 = 0 units, 121 - 150=1 unit, 151 - 180 = 2 units, 181 - 210 = 3 units, 211 - 240= 4 units, 241 - 270= 5 units, 271 - 300 = 6 units, 301 - 330 = 7 units, 331 - 360=8 units 361 - 400 = 9 units, greater than 400 call the doctor. If bs (blood sugar level) 70 or less - give 4 ounces juice and repeat bs in 15 min, bs - check prn (as needed) s/s (signs and symptoms) hyper/hypoglycemia, notify md (medical doctor) for bs (blood sugar) <50 or >400 recheck within 2 hours if 200 and resident is symptomatic. Glucagen ij (injection) 1 mg (milligram) im (intramuscularly) if blood sugar is less than 60 and resident is unresponsive/unable to swallow. Recheck blood sugar in 15 minutes and call MD.</p> <p>On 03/09/13, nursing staff documented administering 5 units of Novolog at breakfast even though blood sugar was 80 and they should</p>				

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	<p>have subtracted 2 units and only given 3 units of Novolog.</p> <p>On 02/08/13, nursing staff administered 5 units of Novolog at breakfast even though the resident's blood sugar level was 74.</p> <p>3. The clinical record for Resident #2 was reviewed on 03/08/13. The resident had diagnoses, including but not limited to, insomnia, hyperlipidemia, vitamin D, dysphasia, osteoarthritis, hypothyroidism, major depression with recurrent episodes of severe psychotic behavior, htn (hypertension), anemia, anxiety, dm (diabetes mellitus), diverticulosis of colon, hernia, joint disorder, dependent personality disorder, esophagitis, polyneuropathy and diabetes.</p> <p>The physician orders regarding insulin and blood glucose monitoring and parameters for March 2013, included the following: Levemir inj (injections)-inject 18 units sq (subcutaneous) qd (daily) at 9 PM. Levemir inj 70 units sq qd at 7:30 A.M., bs 70 or less - give 5 ounces juice and repeat bs in 15 minutes, bs - check prn s/s hypo/hyperglycemia, notify md for bs <50 or >400, glucagon 1 mg inj inject 1 ml, im</p>						

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	<p>(intramuscularly) if blood sugar is <60 and resident is unresponsive/unable to swallow. Recheck blood sugar in 15 minutes and notify MD.</p> <p>Review of the Medication Administration Record (MAR) for March for Resident #2, indicated on 03/01/13 at 9 pm, the resident's blood sugar was 85 and the 9 pm Levemir insulin was not given due to the blood sugar level of 85. On 03/03/13 at 9 pm , the resident's blood sugar level was 78 and the 9 pm, Levemir insulin dose was held due to the resident's blood sugar level of 74.</p> <p>On 03/04/13 at 8:30 P.M, the resident's blood sugar level was 48 and the resident's 9 pm Levemir insulin dose was held. The resident was documented as having been given a snack with juice and the physician notified . A recheck of the resident's blood sugar level at 9 pm was documented as 109, however, the resident still was not given the routinely scheduled Levemir insulin dose. On 03/05/13 at 7 am the routinely scheduled Levemir insulin was held due to a blood sugar level of 66. There was no documentation of a snack being given or recheck of blood sugar until 11:30 A.M. At 11:30 A.M., Resident #2's blood sugar was</p>				

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	<p>228.</p> <p>On 03/05/13 at 9 pm, the Levemir insulin was held due to a blood sugar level of 87.</p> <p>Review of the February 2013 MAR indicated on 02/01/13, 02/19/13, and 02/28/13 at 9 PM , the Levemir insulin was held due to blood sugar levels of 75, 77, and 95.</p> <p>Interview with RN #1, on 03/12/13, indicated Resident #25 had a very difficult sliding scale order and the pharmacy printed the MAR and would not print the sliding scale documentation on the same page and it did cause some errors. In addition, she indicated Resident #2's Levemir insulin was changed on 03/05/13 and was lowered due to the resident's low blood sugar levels. She indicated the insulin had been held because the resident had "low blood sugar and if they had given the insulin the blood sugar levels would have dropped too low."</p> <p>3.1-35(g)(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 there was an accurate system in place for reconciliation of a liquid</p>	F000431	It is the intent of this facility to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	04/12/2013			

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	<p>controlled substance for 1 of 4 med carts observed. (South 1 cart).</p> <p>Findings include:</p> <p>On 3/13/13 at 10:39 A.M., liquid Lortab (medicine for pain) was observed in the South 1 hall medication cart ordered for Resident #39. The controlled substance record for Resident #39's Lortab, indicated there was 80 mL's (milliliters) left in the bottle. However, the bottle of Lortab pain medication was visually inspected and noted to only contain 70 millileters. Both RN #1 and LPN #2 visually inspected the bottle of Lortab and they both indicated there was "...at least 70 mL's left..." Resident #39's prescribed dose was "...10 mL's per G (gastrostomy) tube every 8 hours as needed for moderate to severe pain...."</p> <p>On 3/13/13 at 10:45 A.M., an interview with RN #1 indicated "...since the count was off by exactly 10 mL's someone probably gave the medication and forgot to write it on the log sheet. I will need to do an investigation of this...."</p> <p>On 3/13/13 at 2:00 P.M., review of "Controlled Drugs Count Record" for February 2013 and March 2013,</p>		<p>reconciliation; and determines that drug records are in order and than an account of all controlled drugs is maintained and periodically reconciled. Resident #39 remains in the facility and suffered no negative consequences as a result of this finding. Resident #39's recored was reviewed and the missing 10 cc was found. It had been given, but was not documented per P&P. The nurses who had signed and documented the count, which was inaccurate, were counseled for failure to notify the DON of the inaccurate count so that an investigation could be immediately started per facility policy. All residents with a controlled substance could be affected by this deficient practice. All resident's records, who are on a controlled substance, have been reviewed for accuracy. A mandatory inservice for all nurses will be held on 4/5/13 tp review the following policy: COUNTING AND DISPOSING OF SCHEDULE II NARCOTICS - Exhibit #10 (specifically H, I, J, & K) Reconciliation of controlled substances will be reviewed through use of the QA tool ADMINISTRATIVE SERVICES REVIEW - Exhibit # 11 Any discrepancies will be investigated/addressed and findings submitted to the QA committee for review monthly. Nursing Responsible DON/Designee</p>		

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	<p>received from RN #1 indicated "Signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drugs Count Record." Four staff signatures are present on the Controlled Drug Count Record for February 21,22,23,24,25,26,27 and 28, 2013. Four staff signatures are present on the Controlled Drug Count Record for March 1,2,3,4,5,6,7,8,9,10,11 and 12, 2013. Three staff signatures are present for March 13, 2013.</p> <p>On 3/13/13 at 2:20 P.M., review of the Medication Administration Record (MAR) for February 2013 indicated the missing Lortab 10 mL's was given on 2/21/2013 at 7:30 P.M.</p> <p>On 3.13.13 at 2:15 P.M., review of the current "Counting and Disposing of Schedule II Narcotics" policy dated 10/21/2009, indicated "When a scheduled II drug is administered, the licensed nurse or QMA (Qualified Medication Aide) will complete the count sheet indicating the date and time of administration...Amount remaining and signature. At the end of each shift, the oncoming nurse and</p>		Responsible				

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	<p>the off going nurse will count the drugs and reconcile them with the count sheets. If the count is off, investigation will be started immediately. The DON (Director of Nursing) will be notified of the discrepancy and will make every attempt to reconcile the discrepancy...."</p> <p>3.1-25(e)(3)</p>			

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F000456 SS=D	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on record review and interview, the facility failed to ensure 1 of 2 mechanical lift scales utilized by the facility was calibrated to ensure accuracy of weights.</p> <p>Finding includes:</p> <ol style="list-style-type: none"> On 3/18/13 at 10:00 A.M., record review of weights for resident #7 indicated her weight on admission, 12/21/12, was 197.0 pounds when weighed by a wheelchair. On 12/23/12, her weight was 197.0 pounds when weighed by a mechanical lift scale. On 12/29/12 her weight was 178.6 pounds when weighed by a mechanical lift scale. On 1/14/13, her weight was 168.6 pounds when weighed by a mechanical lift scale. On 2/3/13, her weight was 182.5 pounds when weighed by wheelchair scale. <p>Interview with the Director of Nursing, on 03/18/13 at 10:35 A.M., indicated when a discrepancy in weights were noted, the resident was put on weekly weights. When asked about the discrepancy regarding the weight loss</p>	F000456	<p>It is the intent of this facility to maintain all essential mechanical, electrical and patient care equipment in safe operating condition. Resident #7 has been discharged to home and suffered no negative consequences as a result of this finding. All residents weighed with a mechanical lift/scale have the potential to be affected by this deficient practice. This lift was removed from service until it can be properly calibrated. All scales are scheduled to be re-calibrated by Medical Servicing per agreement on 4/2/13. See Exhibit #12 and #13. Two of the scales were re-calibrated and two scales have been removed from service for repair. These will be re-calibrated when repairs have been completed. Scales are on MONTHLY PREVENTIVE MAINTENANCE REPORT (under Nursing Equipment) Exhibit # Any time a resident's weight shows a significant change and cannot be explained by any other means - the mechanical lift/scale will be taken out of service by maintenance until it can be adjusted/re-calibrated/repared. A mandatory inservice will be held on 4/5/13 and staff will be reminded to notify maintenance</p>	04/12/2013			

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	<p>noted for Resident #7 between the weights obtained from the mechanical lift scale and the wheelchair weights. She indicated she would check with the Maintenance supervisor and check to see if there had been any issues with the scales.</p> <p>On 3/18/13 at 12:15 P.M., interview with Employee #3, the Maintenance Supervisor, indicated..."The facility has 2 mechanical lifts currently used to weigh resident's. The mechanical lifts are to be calibrated annually by an outside company. When the lifts are calibrated the company puts a colored sticker on them with the date it was calibrated. One out of two lifts did not get calibrated because it did not have an updated sticker on it. It would be hard to tell which mechanical lift was used to weigh this particular resident...."</p> <p>On 3/18/13 at 12:15 P.M., review of the current "Medical Equipment Servicing Agreement," dated 6/21/2004, received from Employee #4 (Administrator) indicated "Document each calibration and safety test or routine repair in a manner that is compatible to the requirements of Miller Health System."</p>		<p>immediately if the accuracy of any equipment is in question. The following QA tools will be utilized to ensure that the equipment is in proper working order: MAINTENANCE SERVICES REVIEW - Exhibit #16 PREVENTIVE MAINTENANCE REPAIR REPORT - Exhibit #17 These tools will be completed monthly and findings reported to the QA committee for monthly review. Maintenance Responsible Administrator will Monitor</p>				

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	<p>On 3/18/13 at 12:15 P.M., review of the "Calibration Invoice" invoice number 1482-25004225, dated 10/18/12, indicated Invacare Lift Scale model number RLS6 passed the equipment calibration and safety test.</p> <p>Interview with the Administrator, on 03/18/13 at 2:00 P.M., indicated the facility felt the weight loss was not a true loss but a mechanical lift and/or user error with the equipment. She indicated the facility had discussed the weight discrepancies at the time and felt the documented weights were not accurate.</p> <p>3.1-19(bb)</p>				