

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/20/2012
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN 47246
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F0000	<p>This survey was for the Recertification and State Licensure Survey.</p> <p>Survey dates: April 17, 18, 19, and 20, 2012</p> <p>Facility number: 000286 Provider number: 155579 AIM number: 100291000</p> <p>Survey team: Jill Ross, RN-TC Cheryl Fielden, RN Janie Faulkner, RN Diana Sidell, RN Susan Worsham, RN</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 9 Medicaid: 40 Other: 17 Total: 66</p> <p>Sample: 15 Supplemental Sample: 1</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	Millers Merry Manor of Hope respectfully requests paper compliance. Please accept the following plan of correction for F-Tag 157, F-Tag 241, and F-Tag 541 as our credible allegation of compliance	

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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	Quality review completed on April 26, 2012 by Bev Faulkner, R.N.				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to notify timely the resident's physician of the resident having low blood sugars and that the resident's insulin ordered before meals</p>	F0157	Resident # 39 remains a resident at this facility. An order for clarification to administer insulin after meals was received on 4/20/12. This was an isolated problem that has been	05/18/2012

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	<p>was given after meals. This affected 1 of 15 residents reviewed for physician notification in a sample of 15. (Resident # 39)</p> <p>Findings included:</p> <p>During observation of the medication pass on 4/18/2012 at 9:03 A.M., RN # 1 was observed to administer 12 units of Humalog insulin subcutaneous 2 inches above the umbilicus of Resident # 39. RN #1 documented on the resident's Medication Administration Record indicating the insulin was given at 7 AM.</p> <p>Review of the Medication Administration Record indicated, Humalog insulin 100/ML 12 units SUB-Q was to be given as a routine order daily before meals at 7 AM, 11:45 AM. &amp; 5:15 PM.</p> <p>Interview with RN # 1 on 4/18/2012 at 9:05 A.M. regarding the time Resident # 39 eats breakfast and she replied, "he just finished eating before I gave him his insulin, we have to do that or his blood sugar drops before he gets breakfast." "No, I don't have a clarification order, I'm new and I was told that is what we have to do for him to keep his blood sugars from dropping."</p> <p>During review of Resident # 39's</p>		<p>corrected.All residents with orders for blood sugars and/or insulin may be affected by this deficient practice. An audit was conducted on all identified residents on 5/7/12.No blood sugars were noted to be outside normal parameters. No deficiencies were noted.To prevent recurrence of this deficient practice, all licensed nursing staff will be mandated to attend an inservice to include:1. Family and physician notification of blood sugars outside of call parameters with any orders received.2.) Hypoglycemia/hyperglycemia flow sheets with protocols. See Attachments A, B, FEach nurse will receive personal copies of Attachments A &amp; B and the flow sheets will also be placed in the front of the MAR.A QA form named Glucose Monitoring Review (Attachment C) will be used for audits. The DON or designee will conduct audits twice weekly for 1 month, weekly for 1 month, monthly for 4 months, and quarterly thereafter. The consultant pharmacist will review monthly and prn as needed to check for compliance. The QA Committee will review all audits and make recommendations as deemed appropriate.</p>		

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	<p>Physician Recapitulation Orders, signed and dated by the attending physician on 4/1/12, provided by the Director of Nursing on 4/18/2012 at 9:25 A.M., indicated the following:</p> <p>"Diabetic-Insulin routine orders Humalog inj 100/ML 12 Units Sub-Q: Daily before meals at 7 AM, 11:45 AM, &amp; 5:15 PM for Diabetes Lantus inj 100/ML 28 Units Sub-Q: Daily at 8 PM. Hold FOR BS[blood sugar] &lt;150 for Diabetes" with effective date of 11/18/2010.</p> <p>"Diabetic PRN[as needed] orders....BS-NOTIFY MD [medical doctor] for BS &lt; [less than] 50 or &gt; [greater than] 400" with effective date of 9/9/2009.</p> <p>Received of a care plan (page 11) for Resident # 39, on 4/19/2012 at 3:45 P.M., from the Minimum Data Set Coordinator who stated, "a revision of the care plan was completed by the ADON yesterday to clarify the MD was aware of resident receiving insulin after meals."</p> <p>During review of care plan (page 11) with a last care plan review date, completed 4/11/2012, "Focus Potential for hypo/hyperglycemia Signs of hyper:Increased urination,</p>			

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	<p>Weakness/fatigue, blurred vision, N/V[nausea/vomiting], Abd[abdominal] cramping, headache, sweet breath odor. Signs of hypo:Cool clammy skin, rapid HR[heart rate], nervousness/tremors, decreased LOC, behavioral changes, visual changes, tingling sensation around mouth."</p> <p>"Primary MD aware that blood sugar results are obtained at 6 am and insulin coverage is administered after breakfast due to residents history of blood sugar dropping too low if insulin is administered before he eats breakfast" Date initiated: 9/14/2009 Care plan Revision on: 4/18/2012 Care plan</p> <p>Review of Resident # 39's Medication Administration Records for March and April 2012, indicated Resident # 39 received Glucagon at 8 P.M. on March 21, 2012 and received chocolate milk on March 21, 2012 at 6 A.M. for BS of 55, and received chocolate milk on March 25, 2012 at 6 A.M. for BS of 47, and received chocolate milk on March 26, 2012 at 6 A.M. for BS of 57. There was no documentation of notification to the physician on the Medication Administration Records, in any of the resident's nursing notes, or clarification order to indicate the physician was notified prior to changing the time of the Humalog insulin administration to after</p>						

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	<p>meals.</p> <p>A copy of Resident # 39's Physician Recapitulation Orders were reviewed with the Assistant Director of Nursing on 4/20/2012 at 10:50 A.M. The Assistant Director of Nursing stated, "yes, these are Resident # 39's current physician orders". "I should have obtained a clarification order to give Humalog Insulin after meals."</p> <p>On 4/20/2012 at 12:30 P.M., the ADON provided a telephone clarification order dated 4/20/2012 at 12 P.M., "Humalog 12 units sub Q p[after] meals at 8 AM, 12:30 PM &amp; 6 PM for diabetes".</p> <p>3.1-5(a)(3)</p>				

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, facility failed to ensure a cover was placed on a resident's urinary catheter drainage bag. This affected 1 of 3 residents reviewed for dignity in a sample of 15. (Resident # 7)</p> <p>Findings included:</p> <p>During the initial tour and interview with the ADON on 4/17/2012 at 10:00 A.M., the ADON indicated that Resident # 7 was on Hospice due to end stage congestive heart failure and has a Foley catheter for comfort. Resident #7 was observed to be resting in bed with eyes closed.</p> <p>On 4/18/2012 at 9:23 A.M., the record review of Resident # 7, indicated the resident was admitted with, but not limited to the following diagnoses; Atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, hypertension, osteoporosis, peripheral neuropathy, anxiety, and debility.</p>	F0241	<p>Resident # 7 remains a resident at this facility. Resident # 7 has a urinary drainage bag placed in a cover for dignity and respect. All residents with urinary catheter drainage bags are identified as potentially affected by this deficient practice. An audit on 5/7/12 noted that all urinary catheter drainage bags were in covers with no deficiencies noted. All nursing staff will be in-serviced on need to cover urinary catheter drainage bags to preserve resident dignity and respect. (See Attachment F.) A QA form named Foley Drainage Bag Placement (Attachment D) will be used to conduct audits. The DON or designee will audit daily for 1 week, weekly for 1 month, monthly for 4 months and quarterly thereafter. The QA Committee will review all audits and make recommendations as deemed appropriate.</p>	05/18/2012

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	<p>On 4/20/2012 at 6:30 A.M., Resident # 7 was observed in bed with a bulging urinary catheter bag hanging on the right side of her bed and fully visible from the hall way. There was no cover on the drainage bag.</p> <p>During an observation of Resident # 7 on 4/20/2012 at 2:30 P.M., the resident was in bed lying on her left side, facing the window with her eyes closed. The urinary catheter bag with 150 cc of urine was hanging on the right side of the bed and clearly visible from the hall way. There were five visitors in Resident # 7's room sitting and facing the right side of the resident's bed.</p> <p>Review of Policy and Procedure for Foley Catheter Care &amp; Maintenance provided by the ADON on 4/20/2012 at 4:00 P.M., indicated "A. Purpose.... E. Placement of Catheter Tubing Procedure 1. When in bed or wheel chair: a. Position tubing with no tension b. Place in a catheter cover bag underneath wheelchair or on side of bed c. Ensure bag or tubing is not touching floor"</p> <p>3.1-3(t)</p>				

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F0514 SS=E	<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 record review and interview, the facility failed to ensure accurate and complete documentation on the medication administration record (MAR) in that:</p> <ul style="list-style-type: none"> <li>-Medications were not initialed as given (Resident #61 and #65)</li> <li>-Placement checks for a medication patch was not documented (Resident #65)</li> <li>-Injection sites for insulin were not documented (Resident #5, #38 and #65)</li> <li>-No sliding scale insulin was documented as given (Resident #65)</li> <li>-No documentation of Blood Sugar results (Resident #65)</li> <li>-Blanks on the MAR ' s where the medication side effects were documented (Resident #65)</li> <li>-No documentation the affects of pain</li> </ul>	F0514	Residents # 5, # 12, # 38, # 61, and # 65 remain resident of this facility. All residents at facility are identified as potentially affected by this deficient practice. An audit was conducted on 5/7/12 to identify any incomplete documentations. A mandatory in-service for all licensed nursing staff will be held to re-educate on MAR documentation completion. ( See Attachment F). A QA form Documentation Completion of MAR's ( Attachment E) will be used to conduct audits. The DON or designee will conduct audits weekly for 1 month, monthly for 4 months and quarterly thereafter. The QA Committee will review audits and make recommendations as deemed appropriate.	05/18/2012			

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	<p>medication that was given (Resident #12)</p> <p>-Blank spaces for edema and cardiac assessments (Resident#12)</p> <p>-No BP charted before giving Lasartan as ordered (Resident #12)</p> <p>-Medications circled with no documentation as to why they were circled (Resident #12)</p> <p>-Medications discontinued one day but initialed they were given the next morning (Resident #12)</p> <p>This affected 5 of 15 residents reviewed for accurate and complete records in a sample of 15. (Residents #5, #12, #38, #61 and #65)</p> <p>Findings include:</p> <p>1. Resident #5 ' s record was reviewed on 4/18/2012 at 9:50 a.m. The record, which included the orders titled "Active orders for March, 2012," included but was not limited to the following diagnosis: diabetes.</p> <p>The "Active orders for March, 2012" included, but was not limited to:</p> <p>1. "...Check BS (blood sugar) 2 X (times) daily at 6 AM and 4 PM ...Inject novolog per sliding scale...."</p> <p>Review of Resident #5 ' s MAR labeled "Schedule for March, 2012" indicated,</p>						

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	<p>but was not limited to the following:</p> <p>1. "...Check BS 2 X daily at 6 AM ...Inject novolog per sliding scale."</p> <p>The March 10, 2012, 6:00 a.m. injection site for insulin was not documented.</p> <p>2. Resident #38's record was reviewed on 4/17/2012 at 12:45 p.m. The record, which included the orders titled "Active orders for February, 2012," "Active orders for March, 2012," and "Active orders for April, 2012," included but were not limited to the following diagnosis: diabetes.</p> <p>The active orders for February, March and April, 2012, included but were not limited to:</p> <p>1. "...Check BS 2 X daily 6 AM and 11 AM ...Inject humalog per sliding scale ...."</p> <p>2. "...Check BS 2 X daily 4 PM and 8 PM ...Inject humalog per sliding scale ...."</p> <p>Review of Resident #38's MAR labeled "Schedule for February, 2012," "Schedule for March, 2012," and "Schedule for April 2012," indicated but was not limited to the following:</p> <p>1. "...Check BS 2 X daily at 6 AM ...Inject humalog per sliding scale ...."</p>			

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	<p>The February 11, 2012, 6:00 a.m., and March 10, 2012, 6:00 a.m., injection site for insulin was not documented.</p> <p>2. "...Check BS 2 X daily at 4 PM and 8 PM...Inject humalog per sliding scale..."</p> <p>The February 11, 2012, 8:00 p.m., March 5, 2012, 4:00 p.m., and March 21, 2012, 4:00 p.m. and 8:00 p.m., injection site for insulin was not documented.</p> <p>3. Resident #61 's record was reviewed on 4/20/2012 at 2:25 p.m. The record which included the orders titled "Active orders for February, 2012," "Active orders for March, 2012," and "Active orders for April, 2012," included but was not limited to the following diagnoses: diabetes, convulsions, osteoporosis (thinning of bones), dementia, major depressive disorder and pure cholesterolemia (high cholesterol).</p> <p>The active orders for February, 2012, included but were not limited to: Aricept 10 mg by mouth every day at 8:00 p.m., for dementia. Calcium with Vitamin D 600 mg, one by mouth at 12 noon every day, for osteoporosis. Dilantin 100 mg one capsule 3 X daily by mouth at 7:00 a.m., 4:00 p.m., and 8:00</p>			

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	<p>p.m., for seizure disorder. Keppra 500 mg, 3 tablets 2 X daily by mouth at 7:00 a.m., and 8:00 p.m., for seizure disorder. Lipitor 20 mg one daily by mouth at 8:00 p.m., for hypercholesterolemia (high cholesterol). Fosamax 70 mg by mouth, once a week at 6:00 a.m., sit up for 30 minutes after taking. Take with 6-8 ounces of water for osteoporosis.</p> <p>Review of Resident #61 s MAR's labeled "Schedule for February 2012," indicated but was not limited to the following: - Aricept 10 mg one tablet by mouth daily at 8:00 p.m. The February 27 and 29, 2012, 8:00 p.m., dose was not initialed as given.</p> <p>- Calcium with Vitamin D 600 mg one tablet daily by mouth at 12 noon. The February 29, 2012, 12:00 p.m., dose was not initialed as given.</p> <p>- Dilantin 100 mg one capsule by mouth 3 times daily at 7:00 a.m., 4:00 p.m., and 8:00 p.m. The February 27 and 29, 2012, 4:00 p.m., and 8:00 p.m., dose was not initialed as given.</p> <p>- Keppra 500 mg 3 tablets 2 times a day, at 7:00 a.m. and 8:00 p.m. The February 27 and 29, 2012, 8:00 p.m.,</p>						

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	<p>dose was not initialed as given.</p> <p>- Lipitor 20 mg one tablet by mouth at 8:00 p.m. The February 27 and 29, 2012, 8:00 p.m., dose was not initialed as given.</p> <p>- Lexapro 10 mg one tablet daily by mouth at 8:00 p.m. The February 27 and 29, 2012, 8:00 p.m., dose was not initialed as given.</p> <p>4. Resident # 65 record was reviewed on 4/19/2012 at 10:00 a.m. The record which, included the orders titled "Active orders for February, 2012," "Active orders for March, 2012," and "Active orders for April, 2012," included but was not limited to the following diagnoses: diverticulitis of small intestine (small bulging pouches in the small intestine), reflux esophagitis (caused by stomach acid that splashes into the esophagus), congenital coronary artery anomaly, history of TIA (transient ischemic attack-stroke) and diabetes.</p> <p>The active orders for February, March and April, 2012, included but were not limited to: " Plavix 75 mg 1 tab (tablet) by mouth: daily at 8 PM for thrombotic (blood clot) event prevention." "Nexium *Do not crush* 40 mg 1 cap</p>				

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	<p>(capsule) by mouth: daily at 6 AM for GERD (gastroesophageal reflux disease)" "Senna Plus 8.6 mg 1 tab by mouth: 2 X (2 times) daily at 7 AM and 8 PM."</p> <p>Review of Resident # 65's MAR's labeled "Schedule for February 2012," "Schedule for March 2012," and "Schedule for April 2012," indicated but was not limited to the following:</p> <ul style="list-style-type: none"> <li>- "Plavix 75 mg-Qty (quantity) to administer: 1 tab-by mouth-daily at 8 PM for thrombotic event prevention, start date 7/20/2011. "</li> <li>The February 26, 2012, 7:00 p.m., dose was not initialed as given.</li> <li>- "Senna Plus 8.6 mg-Qty to administer: 1 tab-by mouth-2 X daily at 7 AM and 8 PM hold for loose stools for constipation, start date 7/20/2011." The February 26, 2012, 8:00 p.m., dose was not initialed as given.</li> <li>- "Risperdone 1 mg-Qty to administer: 1 tab-by mouth-2 X daily at 7 AM and 7 PM for agitation, dementia, anxiety and psychosis, start date 11/23/2011." The February 1, 2012, 7:00 p.m., dose was not initialed as given.</li> <li>- "Risperdone 0.5 mg P.O. 7 AM, 7 PM." The February 26, 2012, 7:00 p.m. dose was not initialed as given.</li> </ul>			

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	<p>- " Nexium *Do not crush* 40 mg-Qty to Administer: 1 cap-by mouth-daily at 6 AM for GERD, start date 7/20/2011." The April 8, 2012, 6:00 a.m., dose was not initialed as given.</p> <p>- "Check placement of fentanyl patches every shift, start date of 9/12/2011." The February 24, 2011, evening placement was not initialed as checked. The February 4, 7, and 12, 2012, night placement was not initialed as checked.</p> <p>- "...Check BS (blood sugar) 2 X daily at 4 PM and 8 PM ...Inject novolog per sliding scale ..." The February 16, 2012, 4:00 p.m., site for injection of insulin was not documented. The February 22, 2012, 8:00 p.m. site for injection of insulin was not documented.</p> <p>- "...Check BS 2 X daily at 6 AM and 11 AM ...Inject novolog per sliding scale ... " The February 18, 2012, 11:00 a.m., site for injection of insulin was not documented.</p> <p>- The February 18, 2012, 11:00 a.m., BS was documented as 206; no insulin was documented as given.</p> <p>- The April 11, 2012 8:00 p.m., BS was not documented. The April 30, 2012, 6:00 a.m. BS was not documented.</p>			

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	<p>- " Anxiolytics-monitor side effects each shift ..." The March 27, 2012, day monitoring was not documented.</p> <p>- " Sedative/hypnotic-monitor side effects each shift ..." The April 8, 2012, night monitoring was not documented.</p> <p>During an interview on 4/20/2012 at 9:35 a.m., with the ADON (Assistant Director of Nursing) and DON (Director of Nursing) verified that documentation was missing on the MAR's. In a review of the resident's records with the ADON and DON, no other documentation was found regarding the missing information on the MAR ' S.</p> <p>A policy and procedure received on 4/20/2012 at 10:25 a.m., from the ADON, titled "Medication Administration Procedure " included, but was not limited to the following: "...23. Document initials on the administration record and any other assessment/information needed...."</p> <p>5. Resident #12's record was reviewed on 4/19/12 at 11:45 a.m. The record indicated Resident #12 had diagnoses that included, but were not limited to: Diabetes, Chronic Respiratory Failure,</p>				

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	<p>COPD, Obesity, Sleep Apnea, Atrial Fibrillation, Chronic Kidney Disease Stage III, depression and high blood pressure.</p> <p>In review of the Medication Administration Records (MARs) there were found to be medications circled as though they were not given with no documentation as to why they were not given. These medications were: Trazadone 50 mg for depression at 9:00 p.m. on 3/14/12; Lasix 40 mg for high blood pressure at 12 p.m. on 4/9/12 and 4/13/12; Neurontin 200 mg for diabetic neuropathy at 12:00 p.m. for 4/9/12, 4/10/12, and 4/13/12.</p> <p>The record indicated there were medications that were discontinued on 3/13/12, but charted as being given for the morning doses on 3/14/12. These medications were: Ciprofloxacin Ophthalmic Eye Drops (eye drops preparing for cataract surgery), Prednisolone Acetate Ophthalmic Eye Drops, and Lasix 40 mg.</p> <p>The following medications or treatments had not been initialed as given: 3/14/12 and 4/19/12- Neurontin 200 mg at 1:00 p.m. 3/17/12, 3/18/12, 3/28/12, and 3/31/12- BIPAP (sleep apnea machine) for the</p>			

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	<p>10:00 p.m. to 6:00 a.m. shift 3/25/12- Amiodarone 200 mg (for high blood pressure) at 7:00 a.m. 3/10/12 and 3/19/12 at 12:00 p.m. Lasix 40 mg 4/17/12 at 7:00 a.m. Metoprolol 50 mg (for high blood pressure) 4/3/12 at 7:00 a.m. and 4/13/12 at 7:00 p.m. Pulmicort (for lung problems) 4/9/12 and 4/13/12 at 8:00 a.m. Prednisolone Eye Drops 3/26/12 7:00 p.m. Augmentin 875 mg (antibiotic)</p> <p>Review of Physician's orders on 4/19/12 at 11:45 a.m., dated 3/17/12, included "edema assessments to be done on each shift for all extremities" were not charted as being completed on 3/12/12 night shift, and 3/8/12 and 3/14/12 on evening shifts.</p> <p>Also ordered were "cardiac assessments to be done every shift" were circled as though they were not done for night shift for 3/17/12, and every night shift through and including 3/31/12 with no explanation as to why they were not circled (a circled service means it was ordered but not done).</p> <p>An order for "Lasartan 100 mg po (by mouth) Q day (every day) if BP (blood pressure) is above 100." No blood pressures were documented prior to</p>						

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	<p>giving Lasartan on 3/22/12 or 3/13/12 at 6:00 a.m., while the medication was initialed that it was given.</p> <p>When insulin injections were charted as given there was no documentation where these injections were placed for 3/19/12 at 11:00 a.m., 3/11/12 and 3/12/12 at 6:00 a.m., for 3/25/12 through 3/29/12 at 8:00 p.m.</p> <p>There was no documentation for the effects of pain medications given as follows:</p> <p>3/6/12, 9:30 p.m., when Ultram was given for leg pain at a pain level of an 8(a pain scale of 1 -10 is used with 1 being very little pain and 10 being very bad pain). 3/8/12, at 5:40 a.m. when Ultram was given for leg pain at an 8 pain level. 4/12/12, at 10:30 a.m., when Hydrocodone was given for buttock pain. 4/17/12 at 1:30 p.m. when Hydrocodone was given for back pain at a 9. 4/18/12, at 1:00 p.m. when Hydrocodone was given for bladder pain at pain level of 8. 4/19/12, at 1:30 p.m. when Hydrocodone was given but there was no reason why it was given or what affect the pain medicine had on the pain.</p> <p>There were Duoneb breathing treatments</p>						

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	<p>charted as being done but no assessments were charted on: 3/12/12 at 11:00 a.m., 3/3/12 at 11:00 a.m., 3/4/12 at 4:00 p.m. and 8:00 p.m., and 3/16/12 at 8:00 p.m. The physician's orders were for vital signs (blood pressure, pulse, and respirations), lung sounds and O2 SATs to be done before and after breathing treatments.</p> <p>In interview with the ADON (Assistant Director of Nursing) on 4/20/12, at 12:30 p.m., she said, "If it is not charted it is considered not done even though I believe it was and just wasn't documented."</p> <p>In review of the facility's policy and procedure on "Medication Administration Procedure" received on 4/20/12, at 10:35 a.m., from the ADON and revised on 3/23/11, indicated "...23. Document initials on the administration record and any other assessment/information needed...."</p> <p>In review on 4/20/12, at 1:00 p.m. of the policy and procedure "Injection - Subcutaneous Procedure...37. Document initials on the administration record and any other assessment/information needed...."</p> <p>In review on 4/20/12, at 1:00 p.m., of the policy and procedure on "Use of Insulin Flex Pen" received on 4/20/12, at 10:35</p>						

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	a.m., from the ADON indicated "...16. Document administration and site on the Medication Administration Record..."  3.1-50(a)(1) 3.1-50(a)(2)				