

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED  07/29/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN47304		
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 25, 26, 27, 28, 29, 2011</p> <p>Facility number: 000097 Provider number: 155687 Aim number: 100290970</p> <p>Survey team: Karen Lewis, RN, TC Delinda Easterly, RN Betty Retherford, RN Ginger McNamee, RN</p> <p>Census bed type: SNF/NF: 101 Total: 101</p> <p>Census payor type: Medicare: 12 Medicaid: 79 Other: 10 Total: 101</p> <p>Stage 2 Census Sample: 31</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 8/1/11</p>	F0000			

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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F0282 SS=D	<p>Cathy Emswiller RN</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 interview, the facility failed to ensure the nursing staff clarified medication orders when received by the physician in regards to accurate medication dosage for 2 of 10 residents reviewed with physician's orders for medication in a Stage 2 Sample of 31. (Resident #'s 93, and 31)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #31 was reviewed on 7/27/11 at 2:16 p.m.</p> <p>Current diagnoses for Resident #31 included, but were not limited to, Alzheimer's disease, and constipation.</p> <p>Resident #31 had a health care plan dated 5/19/11, which indicated the resident had a problem with alteration</p>	F0282	<p>F282D</p> <p>It is the Living Center's practice to provide services by qualified persons in accordance with each resident's written plan of care.</p> <p>Resident's #31 and 93 orders were complete with dosage when inputted into PCC under nursing administrative order tab at the time order received. Orders failed to print as complete on MAR. Both residents had the orders rewritten under Pharmacy tab in PCC allowing the complete order to be noted on MAR.</p> <p>All residents have the potential to be affected.</p> <p>All residents have had a comprehensive review of MD orders to ensure completeness of medication orders with specific dosages and are reflected on the MARS.</p> <p>No other residents noted to be affected.</p> <p>All licensed nurses were re-in</p>	08/28/2011	

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	<p>in elimination of bowel and bladder, functional incontinence, and a history of constipation. Interventions for this problem included administer bowel medication as ordered and monitor for use and effectiveness.</p> <p>Resident #31 had a current physician's order for the following: "Docusate Sodium (150 mg [milligrams]/15 ml [milliliters]) (Docusate Sodium) 1 Liquid By mouth - Once daily Everyday". Docusate Sodium is a stool softener medication. The original date of this order was 5/31/2011.</p> <p>The July 2011 Medication Administration Record (MAR) indicated the medication was listed as "Docusate Sodium (150mg/15ml) (Docusate Sodium) - By mouth Dose: 1 Order Date: 5/31/2011 Once daily".</p> <p>The MAR lacked information regarding the amount of medication which was equivalent to one dose.</p> <p>During an interview on 7/27/11 at 3:55 p.m., with RN #1, she indicated the order for the Docusate Sodium medication needed to be clarified by the physician regarding the amount of</p>		<p>serviced in regards to medication orders are to be complete with measurable dosages written on MAR.</p> <p>Unit Managers will be responsible for monitoring compliance on a monthly basis during completion of monthly rewrites for preparation of all orders and physicians rounds. All new physician orders will be reviewed daily as part of the clinical start-up process. During start-up the DNS or her licensed designee will be responsible to review new medication orders and MARS for completeness and accuracy.</p> <p>The QA tool (Physician Order Listing Report) will be turned into DNS daily when QA check is complete and licensed designee signs her name and date on report.</p> <p>The Consultant Pharmacist when completing monthly pharmacy reviews for each resident will also, observe for incomplete orders and document on monthly Pharmacy report given to the DNS for follow-up.</p> <p>The DNS will report compliance to QA Committee monthly times 5 months and quarterly thereafter.</p>		

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	<p>medication which was equivalent to one dose.</p> <p>A physician's telephone order dated 7/27/11, for Resident #31 indicated the following: "Docusate Sodium (150mg/15ml) (Docusate Sodium), 15ml, By mouth QD Once daily Everyday".</p> <p>2.) The clinical record for Resident #93 was reviewed 7/26/11 at 3:46 p.m.</p> <p>Current diagnoses for Resident #93 included, but were not limited to, Alzheimer's disease and diabetes mellitus type 2.</p> <p>Resident #93 had a health care plan, dated 6/2/11, which indicated the resident had a problem of alteration in blood glucose due to non-insulin dependent diabetes mellitus. An intervention for this problem included to administer blood glucose medications as ordered.</p> <p>Resident #93 had a physician's telephone order, dated 7/8/2011, for the following: "Glucose (40 %) (Dextrose (Diabetic Use), 1 By mouth PRN [as needed] glucose gel prn for</p>				

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	<p>blood sugar under 60 and resident responsive".</p> <p>The July 2011 Medication Administration Record (MAR) indicated the medication was listed as: "Glucose (40 %) (Dextrose (Diabetic Use) - By mouth Dose: 1 Order Date: 7/8/2011 glucose gel prn for blood sugar under 60 and resident responsive".</p> <p>The MAR lacked information regarding the amount of medication which was equivalent to one dose.</p> <p>During an interview on 7/28/2011 at 8:55 a.m., with RN #1, she indicated the telephone order for the Glucose medication needed to be clarified by the physician regarding the amount of medication which was equivalent to one dose.</p> <p>A physician's telephone order, dated 7/28/2011, for Resident #91, indicated the following: "Glucose (40 %) (Dextrose (Diabetic Use), 1, By mouth PRN glucose gel 15 gms(grams) prn(as needed) for blood sugar under 60 and resident responsive".</p> <p>3.) Review of the current facility</p>						

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	<p>policy, dated 10/07, titled "Medication Administration", provided by Director of Nursing, on 7/29/11 at 9:45 a.m., indicated the following:</p> <p>"Policy Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medication do so only after they have familiarized themselves with the medication.</p> <p>Procedures</p> <p>Medication Preparation:</p> <p>1. Medications are prepared only by licensed nursing, medical , pharmacy or other personnel authorized by state regulation to prepare medications....</p> <p>...Medication Administration:</p> <p>1. Medications are administered in accordance with written orders of the prescriber....</p> <p>...If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the</p>				

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F0329 SS=D	<p>resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate....".</p> <p>3.1-35(g)(2)</p> <p>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.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure residents with orders for as needed narcotic pain medication were monitored for the administration and/or effectiveness of the medication for 2</p>	F0329	<p>F329</p> <p>It is the practice of the living center that each resident's drug regimen must be free from unnecessary drugs.</p> <p>Resident # 81 and 117's quarterly pain assessments remain current as</p>	08/28/2011	

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	<p>of 3 residents reviewed with orders for as needed pain medication in a Stage 2 Sample of 31. (Resident #'s 81 and 117)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #81 was reviewed on 7/27/11 at 9:00 a.m.</p> <p>Diagnoses for Resident #81 included, but were not limited to, Alzheimer's disease, severe end stage rheumatoid arthritis, and chronic pain syndrome.</p> <p>A health care plan problem, dated 6/9/11, indicated Resident #81 needed pain management and monitoring related to rheumatoid arthritis. Approaches for this problem included, but were not limited to, "Administer pain medication as ordered" and "Evaluate and establish level of pain on numeric scale/evaluation tool."</p> <p>Physician's orders, dated 7/12/11, indicated Resident #81 had an order for a Morphine sulfate (a narcotic pain medication) 30 mg (milligrams) extended release every 8 hours routinely. The resident also had an</p>		<p>was at the time of survey.</p> <p>Resident #81 had medication regimen reviewed by the attending physician with new orders written for medication changes, which includes discontinued PRN Norco pain medication.</p> <p>Resident # 117 had medication regimen reviewed by the attending physician and d/t increased frequency of PRN Norco by one tablet (5/325mg) daily by request of the resident, the routine pain medication was increased and PRN discontinued.</p> <p>All residents receiving PRN pain medication has the potential to be affected.</p> <p>All residents receiving PRN pain medication has had their medication regimen reviewed by the attending physician, any order changes have been implemented.</p> <p>Licensed nursing staff has been re-in serviced on completion of the "Pain Monitoring Tool" with each administration of PRN pain medication.</p> <p>DNS or licensed designee utilizing a QA tool will monitor continued compliance of documentation 5 times a week for 4 weeks and one time weekly thereafter.</p> <p>Consultant Pharmacist will review medication sheets, controlled drug records and Pain Monitoring tool for</p>		

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	<p>order for Norco (a narcotic pain medication) 10/325 mg two tablets every four hours prn (as needed) for pain.</p> <p>The "narcotic sign out sheets" for Resident #81 listed the dates and times the "as needed" Norco pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times:</p> <p>6/13/11 at 8:45 a.m. 6/17/11 at 9:00 a.m. 6/21/11 at 8:30 a.m. 6/24/11 at 9:00 a.m. 7/7/11 at 10:00 a.m. 7/15/11 at 10:00 a.m.</p> <p>The Medication Administration Record (MAR) for June and July 2011 for Resident #81, lacked any information related to the Norco medication having been given on the dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record.</p> <p>2.) The clinical record for Resident #117 was reviewed on 7/27/11 at 1:30</p>		<p>residents receiving a PRN narcotic pain medication on a monthly basis. During the reviews the pharmacist will check for completeness of documentation of medication administration and will make recommendations for the attending physicians as deemed necessary to promote the quality of our residents. DNS or licensed designee will contact attending physician's monthly with pharmacy recommendations.</p> <p>DNS will report findings of QA audits and monthly Pharmacy report to the QA Committee monthly times 5 months and quarterly thereafter.</p>		

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	<p>p.m.</p> <p>Diagnoses for Resident #117 included, but were not limited to, cirrhosis of the liver, ascites, diabetes mellitus, and osteoporosis.</p> <p>A health care plan problem, dated 9/30/10 and last updated on 6/22/11, indicated Resident #117 needed pain management and monitoring related to cirrhosis of the liver and osteoporosis. Approaches for this problem included, but were not limited to, "Administer pain medication as ordered", "Evaluate need to provide medications prior to treatment or therapy", and "Observe for potential medication side effects."</p> <p>Physician's orders, dated 7/13/11, indicated Resident #117 had an order for Norco (a narcotic pain medication) 5/325 mg (milligrams) one tablet routinely two times a day. The order also indicated the resident could have Norco 5/325 mg 1 tablet every four hours prn (as needed) for pain.</p> <p>The "narcotic sign out sheets" for Resident #117 listed the dates and times the "as needed" Norco pain medication was signed out for the resident. Included, but were not limited to, were the following dates</p>				

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	<p>and times:</p> <p>7/2/11 at 1:15 p.m. 7/8/11 at 4:00 p.m.</p> <p>The Medication Administration Record (MAR) for July 2011 for Resident #117, lacked any information related to the Norco medication having been given on the dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record.</p> <p>3.) During an interview with the Director of Nursing (DoN) on 7/28/11 at 10:00 a.m., additional information was requested related to the lack of documentation of administration and monitoring for effectiveness of the pain medication on the dates and times noted above for Resident #81 and #117.</p> <p>During an interview on 7/28/11 at 11:15 a.m., the DoN indicated she had no additional information to provide related to the need for and/or effectiveness of the Norco medication signed out on the dates and times for Resident #81 and #117 noted above. She indicated these concerns had already been identified by the facility</p>				

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	<p>and they were currently auditing the administration of prn medications.</p> <p>4.) The current January, 2011, revised "Pain Management Guideline" was provided by the Director of Nursing on 7/29/11 at 9:45 a.m. The purpose of the guideline was to provide guidelines for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life.</p> <p>The guidelines indicated the following:                      "Functions of appropriate pain management include, but are not limited to: ...Assessing pain and evaluating response to pain management interventions using a pain management scale based on resident self-report or objective assessment for the cognitively impaired....Documenting pain assessment, intervention, and evaluation activities in a clean [sic] and concise manner per the plan of care.... Documentation may appear on the following:                      Clinical Assessment-Clinical Health Status Tool                      Pain Evaluation                      Medication Administration Record (MAR)                      Pain Monitoring Tool                      Interdisciplinary/Nursing Progress</p>						

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	<p><b>Note</b></p> <p>Minimum Data Set [Assessment] (MDS) Care Plan/Immediate Plan of Care (IPOC)...."</p> <p>5.) The current 10/07, "Medication Administration General Guidelines" policy was provided by the Director of Nursing on 7/29/11 at 9:45 a.m. The policy indicated when PRN [as needed] medications are administered, the following documentation is provided:</p> <p>a. Date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection site.</p> <p>b. Complaints or symptoms for which the medication was given.</p> <p>c. Results achieved from giving the dose and the time results were noted.</p> <p>d. Signature or initials of person recording administration and signature or initials of person recording effects.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>				

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F0428 SS=E	<p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the pharmacist noted and reported irregularities in regards to the administration of narcotics for 2 of 3 residents (Resident #81 and #117) reviewed with physician's orders for as needed narcotic medication and failed to identify medication orders were not complete in regards to the dosage to be given for 2 of 10 residents (Resident #31 and 93) reviewed for unnecessary medications in a Stage 2 sample of 31.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #81 was reviewed on 7/27/11 at 9:00 a.m.</p> <p>Diagnoses for Resident #81 included, but were not limited to, Alzheimer's disease, severe end stage rheumatoid arthritis, and chronic pain syndrome.</p>	F0428	<p>F428</p> <p>It is the practice of the living center to have each resident's drug regimen reviewed monthly by a licensed pharmacist.</p> <p>Resident #81 had medication regimen reviewed by the attending physician with new orders written for medication changes, which includes discontinued PRN Norco pain medication.</p> <p>Resident#117 had medication regimen reviewed by the attending physician and d/t increased frequency of PRN Norco by one (5/325mg) daily by request of the resident, the routine pain medication was increased and PRN discontinued.</p> <p>Resident# 31 and 93's orders were rewritten and inputted other pharmacy tab in PCC which allows complete order to be printed on MAR. The original order in PCC reflects specific dosage of 15gm of Glucose gel and 150mg/15ml of Docusate Sodium.</p> <p>All residents have the potential of being affected.</p> <p>All resident's medications will be</p>	08/28/2011	

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN47304		
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	<p>Physician's orders, dated 7/12/11, indicated Resident #81 had an order for a Morphine sulfate (a narcotic pain medication) 30 mg (milligrams) extended release every 8 hours routinely. The resident also had an order for Norco (a narcotic pain medication) 10/325 mg two tablets every four hours prn (as needed) for pain.</p> <p>The "narcotic sign out sheets" for Resident #81 listed the dates and times the "as needed" Norco pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times:</p> <p>6/13/11 at 8:45 a.m. 6/17/11 at 9:00 a.m. 6/21/11 at 8:30 a.m. 6/24/11 at 9:00 a.m. 7/7/11 at 10:00 a.m. 7/15/11 at 10:00 a.m.</p> <p>The Medication Administration Record (MAR) for June and July 2011 for Resident #81, lacked any information related to the Norco medication having been given on the dates and times noted above. The nursing notes for the dates and times noted above lacked any information related</p>		<p>reviewed by the consultant pharmacist no less than once monthly and attending physicians will be notified of written recommendations.</p> <p>Licensed Staff re-in serviced on completing and inputting of medication orders into PCC accurately to allow complete order to be printed on Medication Administration Records. DNS or licensed designee will monitor continued compliance thru the daily clinical start-up process and review all new physician's orders utilizing the Physician Order Listing Report as the QA Tool.</p> <p>DNS met with Consultant Pharmacist in regards to monthly reviews to include controlled drug records, documentation of effectiveness of PRN narcotic pain medication and completeness of medication orders to include specific dosages. Monthly reports will be forwarded to DNS.</p> <p>Consultant Pharmacist will report findings to the QA Committee quarterly and submit a written report monthly.</p>		

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	<p>to the pain medication having been given as signed out on the narcotic record.</p> <p>During an interview with the Director of Nursing (DoN) on 7/28/11 at 10:00 a.m., additional information was requested related to any pharmacy recommendations made for Resident #81 for June and July 2011 when the resident's orders were reviewed by the pharmacist.</p> <p>A pharmacist "Consultation Report", dated 7/5/11, indicated the pharmacist had reviewed Resident #81's clinical record on that date. The report lacked any information related to the discrepancies between the MAR and the narcotic sign out sheets as noted above.</p> <p>2.) The clinical record for Resident #117 was reviewed on 7/27/11 at 1:30 p.m.</p> <p>Diagnoses for Resident #117 included, but were not limited to, cirrhosis of the liver, ascites, diabetes mellitus, and osteoporosis.</p> <p>Physician's orders, dated 7/13/11, indicated Resident #117 had an order for Norco (a narcotic pain medication) 5/325 mg (milligrams) one tablet</p>				

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	<p>routinely two times a day. The order also indicated the resident could have Norco 5/325 mg 1 tablet every four hours prn (as needed) for pain.</p> <p>The "narcotic sign out sheets" for Resident #117 listed the dates and times the "as needed" Norco pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times:</p> <p>7/2/11 at 1:15 p.m. 7/8/11 at 4:00 p.m.</p> <p>The Medication Administration Record (MAR) for July 2011 for Resident #117, lacked any information related to the Norco medication having been given on the dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record.</p> <p>During an interview with the Director of Nursing (DoN) on 7/28/11 at 10:00 a.m., additional information was requested related to any pharmacy recommendations made for Resident #117 for July 2011 when the resident's orders were reviewed by the pharmacist.</p>				

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	<p>A pharmacist "Consultation Report", dated 7/5/11, indicated the pharmacist had reviewed Resident #117's clinical record on that date. The report lacked any information related to the discrepancy between the MAR and the narcotic sign out sheet for the medication signed out on 7/2/11 noted above.</p> <p>3.) The clinical record for Resident #31 was reviewed on 7/27/11 at 2:16 p.m.</p> <p>Current diagnoses for Resident #31 included, but were not limited to, Alzheimer's disease, and constipation.</p> <p>Resident #31 had a health care plan dated 5/19/11, which indicated the resident had a problem with alteration in elimination of bowel and bladder, functional incontinence, and a history of constipation. Interventions for this problem included administer bowel medication as ordered and monitor for use and effectiveness.</p> <p>Resident #31 had a current physician's order for the following: "Docusate Sodium (150 mg [milligrams]/15 ml [milliliters]) (Docusate Sodium) 1 Liquid By mouth - Once daily Everyday". Docusate</p>				

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	<p>Sodium is a stool softener medication. The original date of this order was 5/31/2011.</p> <p>The July 2011 Medication Administration Record (MAR) indicated the medication was listed as "Docusate Sodium (150mg/15ml) (Docusate Sodium) - By mouth Dose: 1 Order Date: 5/31/2011 Once daily".</p> <p>The MAR lacked information regarding the amount of medication which was equivalent to one dose.</p> <p>During an interview on 7/27/11 at 3:55 p.m., with RN #1, she indicated the order for the Docusate Sodium medication needed to be clarified by the physician regarding the amount of medication which was equivalent to one dose.</p> <p>A physician's telephone order dated 7/27/11, for Resident #31 indicated the following: "Docusate Sodium (150mg/15ml) (Docusate Sodium), 15ml, By mouth QD Once daily Everyday".</p> <p>The clinical record indicated the facility's pharmacy consultant had</p>				

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	<p>reviewed Resident #31's clinical record on 7/6/2011. The pharmacy consultant made no recommendations for clarification related to Docusate Sodium medication.</p> <p>4.) The clinical record for Resident #93 was reviewed 7/26/11 at 3:46 p.m.</p> <p>Current diagnoses for Resident #93 included, but were not limited to, Alzheimer's disease and diabetes mellitus type 2.</p> <p>Resident #93 had a health care plan, dated 6/2/11, which indicated the resident had a problem of alteration in blood glucose due to non-insulin dependent diabetes mellitus. An intervention for this problem indicated the staff were to administer blood glucose medications as ordered.</p> <p>Resident #93 had a physician's telephone order, dated 7/8/2011, for the following: "Glucose (40 %) (Dextrose (Diabetic Use), 1 By mouth PRN [as needed] glucose gel prn for blood sugar under 60 and resident responsive".</p> <p>The July 2011 Medication</p>				

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	<p>Administration Record (MAR) indicated the medication was listed as: "Glucose (40 %) (Dextrose (Diabetic Use) - By mouth Dose: 1 Order Date: 7/8/2011 glucose gel prn for blood sugar under 60 and resident responsive".</p> <p>The MAR lacked information regarding the amount of medication which was equivalent to one dose.</p> <p>During an interview on 7/28/2011 at 8:55 a.m., with RN #1, she indicated the telephone order for the Glucose medication needed to be clarified by the physician regarding the amount of medication which was equivalent to one dose.</p> <p>A physician's telephone order, dated 7/28/2011, for Resident #91, indicated the following: "Glucose (40 %) (Dextrose (Diabetic Use), 1, By mouth PRN glucose gel 15 gms(grams) prn(as needed) for blood sugar under 60 and resident responsive".</p> <p>The clinical record indicated the facility's pharmacy consultant had reviewed Resident #93's clinical record on 6/6/2011. The pharmacy consultant made no</p>				

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	<p>recommendations for clarification related to Glucose medication.</p> <p>5. The current 10/07, "Consultant Pharmacist Services Provider Requirements" policy was provided by the Director of Nursing on 7/29/11 at 9:45 a.m. The policy indicated regular and reliable consultant pharmacist services are provided to residents. The procedures included, but were not limited to, communicating to responsible prescriber and the Director of Nursing potential or actual problems detected and other findings related to medication therapy orders at least monthly. Communicate recommendations for changes in medication therapy and the monitoring of medication therapy.</p> <p>3.1-25(i)</p>				