

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 524 ANDERSON RD CHESTERFIELD, IN 46017
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: March 22, 23, 26, 27 and 28, 2012</p> <p>Facility Number: 000524 Provider Number: 155617 AIM Number: 100267090</p> <p>Survey Team: Toni Maley, BSW, TC Tammy Alley, RN Donna Smith, RN</p> <p>Census Bed Type: SNF: 1 SNF/NF: 47 Total: 48</p> <p>Census Payor Type: Medicare: 7 Medicaid: 30 Other: 11 Total: 48</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 4/03/12 by Suzanne Williams, RN</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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F0176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observations, record review and interview, the facility failed to ensure residents were evaluated and/or assessed related to the self administration of their medications for 3 of 17 residents observed during medication pass. (Resident #'s 47, 66, and 70)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 3/27/12 at 9:10 a.m., medication pass was observed. RN #5 was observed to prepare Resident #66's oral medications, which included tramadol (pain), Diovan (hypertension), and Klor-con (potassium replacement). Upon entering the resident's room, RN #5 placed the resident's pills on her bedside table. Next, RN #5 indicated she needed a spoon and left the room with the medications left at the resident's bedside. Resident #66 was observed to take one of her pills from her medication cup on the bedside table during RN #5's absence. <p>The resident's medications were</p>	F0176	F 176 The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation. All residents in the facility have the potential to be affected by this deficient practice but no negative outcomes were observed for any of the identified residents affected by this deficiency. In order to prevent this deficient practice from occurring in the future the facility has held a mandatory all nursing in-service. RN #5 received one on one education and instruction by DON on the administration of meds and the requirement of nursing supervision until medication administration is complete and In-service director completed med pass skills check off and med pass observations with RN #5. The In-service director conducted nurses' training on the proper techniques for completing a med pass and unless the resident is deemed competent to self administer medication, nursing is responsible for supervising medication administration according to physician's orders and	04/27/2012

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	<p>reconciled on 3/27/12 at 9:35 a.m. The resident's diagnoses included, but were not limited to, hypertension, osteoarthritis, and depressive disorder. No information was indicated concerning a self medication administration assessment/evaluation.</p> <p>On 3/28/12 at 9:55 a.m., the Director of Nursing (DON) indicated Resident #66 did not have an assessment/evaluation for self medication administration.</p> <p>2. On 3/27/12 from 1:06 p.m. to 2:13 p.m. during medication pass, the following was observed:</p> <p>a). In preparation, RN #5 was observed to assess Resident #47, and add the medication, Albuterol (bronchodilator), to the resident's medication chamber of his nebulizer mask. She then placed this same nebulizer mask on Resident #47 and started the nebulizer machine. At this same time, RN #5 indicated to the visitor in the room she would be back after his treatment was finished, and she left the room.</p> <p>b). Next, after obtaining Resident #70's respiratory medication from the medication cart, RN #5 entered</p>		<p>manufacturer's recommendations. In addition to nursing training, medication administration/med pass skills check offs are to be completed with all nurses. This will be completed by 4/27/2012. The med pass skills check offs will be completed on 50% of the nurses every month for six months and thereafter each nurse a minimum of 2 times per year. RN #5 will have med pass check offs completed weekly for six weeks and then monthly for 4 months and at least 2 times annually thereafter. All issues will be addressed immediately and the findings reviewed in the quarterly or monthly Quality Assurance meeting.</p> <p>Attachment A – Skill Check Off: The Med Pass</p> <p>Completion date: 4/27/2012</p>		

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	<p>Resident #70's room for his nebulizer treatment. After assessing him, she placed his medication, Duoneb (bronchodilator), into the medication chamber of the resident's nebulizer mask, placed it on him, and turned the nebulizer machine on. She then left the room and indicated to the visitor she would be back after the treatment had been completed.</p> <p>c). As RN #5 returned to Resident #47's room, his visitor was in the hallway and indicated she thought the nebulizer treatment was completed. After RN #5 entered the room and indicated the treatment had been completed, she removed the nebulizer mask and turned the machine off. After assessing the resident, she left the room and returned to the medication cart.</p> <p>At this same time during an interview, RN #5 indicated both residents had visitors in their rooms during the nebulizer treatments, so she did not feel she needed to stay during their nebulizer treatments. She also indicated she felt Resident #70 was alert and orientated. She indicated she would wait 5 minutes and return to Resident #70's room then.</p> <p>d). As RN #5 returned to Resident</p>			

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	<p>#70's room, RN #5 indicated his treatment was also completed. She then removed the nebulizer mask, turned off the machine, and assessed the resident.</p> <p>e). On 3/27/12 at 3:45 p.m., Resident #47's medications were reconciled. The physician order was Albuterol 0.083% 1 vial per nebulizer 4 times a day. The resident's diagnoses included, but were not limited to, congestive heart failure and dementia. No information was indicated concerning a self medication administration assessment/evaluation.</p> <p>On 3/27/12 at 3:50 p.m., Resident #70's medications were reconciled. The physician order was Duoneb per respiratory nebulizer 4 times a day. The resident's diagnoses included, but were not limited to, respiratory failure. No information was indicated concerning a self medication administration assessment/evaluation.</p> <p>On 3/28/12 at 9:10 a.m. during an interview, the DON indicated both Resident #47 and Resident #70 did not have a self medication evaluation to self administer their respiratory treatments. She also indicated she</p>				

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	<p>was unaware if the visitors present during the respiratory treatments were knowledgeable concerning respiratory treatments.</p> <p>3. The "Self Administration of Meds (Medications) Procedure & Assessments" policy was provided by the Administrator on 3/28/12 at 12:25 p.m. This current policy indicated the following:</p> <p>" .13 (sic) Self Administration of Meds Procedure & Assessments:</p> <p>A. Purpose</p> <p>1. To assess residents ability to self-administer medications in a safe manner.</p> <p>...C. PROCEDURE-GENERAL:</p> <p>1. Any resident expressing a desire to self-administer medications must review and sign a Self-Administration request form.</p> <p>2. An assessment of the residents abilities to self-administer meds will be completed prior to initiation of training.</p> <p>...5. Until a determination is made the facility will administer all medications....."</p> <p>The "High Mist Nebulizer or Oxygen Tank Procedure" policy was provided by the DON on 3/28/12 at 8:20 a.m. This current policy indicated the</p>						

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	<p>following:</p> <p>"...Nurse must remain with resident during the treatment, unless the resident has been assessed to be safe to self administer the treatment and has a current physician's order to do so....."</p> <p>3.1-11(a)</p>			
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F0247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on interview and record review, the facility failed to ensure a resident was not moved from one room to another without prior notification and consent by the resident for 1 of 1 resident reviewed who met the criteria for room transfers (Resident #33).</p> <p>Findings Include:</p> <p>Resident #33's clinical record was reviewed on 3/26/12 at 3:00 p.m.</p> <p>Resident #33's current diagnoses included, but were not limited to, hypertension, depressive disorder, and epilepsy.</p> <p>Upon admission on 12/9/11, Resident #33 was admitted to room 211</p> <p>The clinical record indicated that on or around 12/27/11, Resident #33 was moved to room 212. The clinical record, both in paper form and electronic form, lacked any documentation regarding the request for a room move, notification of a room move or reason for a room</p>	F0247	<p>F 247 The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation. All residents in the facility have the potential to be affected by this deficient practice but no negative outcomes were observed for any of the identified residents affected by this deficiency. When Resident #33 moved rooms in December 2011 the facility did ask for permission from both the resident and the POA if it was ok with them that the room move occurred but the facility did not document that request on the proper forms proving that permission was requested and granted. In order to prevent this deficient practice from occurring in the future the facility will be educating all staff involved with the room moves, specifically the Social Services Department, to ensure that every resident and resident POA is notified of any room move or change in roommate and the proper notification paper work is completed and placed on the medical record. This will be monitored by the administrator by a weekly audit of all room moves for the first month and quarterly</p>	04/27/2012	

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	<p>move.</p> <p>During a 3/22/12, 10:47 a.m. interview, Resident #33, who was determined to be interviewable during stage one of the survey process, indicated he had been moved to a new room. He was told the day he was moved. He was not notified prior to that day. The facility did not ask permission. He believed the facility needed his former room for a women's room.</p> <p>During a 3/27/12, 8:51 a.m. interview, the Social Service Director indicated she sometimes documents room moves and changes in the progress notes. She believes Resident #33 was moved because he wasn't happy where he was. At this time, the Social Service Worker reviewed Resident #33's record and indicated she could not find any information or documentation related to the resident's room move.</p> <p>During a 3/27/12, 10:30 a.m., interview, the MDS coordinator indicated Resident #33 moved to room 212 on 12/27/11.</p> <p>Review of a current, undated, facility policy, titled Resident Room Relocation, which was provided by</p>		<p>thereafter. Any issues will be addressed with the staff involved and the findings will be reviewed in the 4/19/2012 Quality Assurance Meeting.</p> <p>Attachment B: QA tool – Room Move Audit</p> <p>Completion date: 4/27/2012</p>		

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	<p>the Social Service Director on 3/27/12 at 9:00 a.m., indicated the following:</p> <p>"Social Services will participate in making all resident room relocation decisions.</p> <p>1. Social Services will evaluate the relocation's impact to the resident prior to initiating the relocation to a different room within the facility. ...</p> <p>4. Social Services will complete the Intra-Facility form, and provide notice to the resident and family once agreement on the move is reached. Social Service will document in the medical record that notice was provided to both resident and family. ..."</p> <p>During a 3/27/12, 10:40 a.m. interview, the DON (Director of Nursing) indicated Resident #33 was moved into a room with another man in order to put two men together and free a room for a female bed. She believed they had asked the resident and received his permission, but she had not been the person assigned to that task, perhaps Social Services had asked him.</p> <p>3.1-3(v)(2)</p>				

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F0253 SS=C	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to maintain an environment that was clean and in good repair for 2 of 2 halls observed. This deficient practice had the potential to impact 48 of 48 residents who resided in the facility. (Room #206, 207, 214, 211, 209, 213, 217, 215, 216, 210, 108, 115, 114, 104, 112, therapy)</p> <p>Findings include:</p> <p>During observation on: 200 Hall</p> <p>3/22/12 at 10:36 a.m., room 207 had 2 nickel-size marred areas in the wall behind the room chair. Around the bed leg at the head, there was a 2 inch build up of a dark substance. In the bathroom, there was a 1 inch area of tile missing next to the toilet with a gap with a dark substance in the gap. There was also one tile in front of the toilet that was discolored gray.</p> <p>3/22/12 at 11:34 a.m., room 214's room and bathroom had floor tiles with gaps between the tiles with a</p>	F0253	F253	04/27/2012	<p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation. All residents in the facility have the potential to be affected by this deficient practice but no negative outcomes were observed for any of the identified residents affected by this deficiency. The areas identified during the survey were rooms 206, 207, 209, 210, 211, 213, 214, 215, 216, 217, 104, 108, 112, 114, 115, therapy department and the fire doors on the 100 and 200 halls. The floor tiles identified in the survey in rooms 207, 210, 211, 214 and 215 have been scheduled to be replaced and a PO has been issued for that replacement (Attachment F – PO and Quote for floor replacement). The areas identified in the survey that require drywall and trim repair and paint are rooms 206, 207, 210, 213, 216, 217 and the therapy department bathroom door frame have been put on a maintenance schedule and will be completed by 4/27/2012. Room 209's window curtain was put back on all the hooks on</p>		

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	<p>build up of a dark substance in the gaps.</p> <p>3/22/12 at 2:30 p.m., room 211 had gaps in numerous floor tiles with a build up of a dark substance in the gaps. The floor in front of the closet had a build up of dust and debris.</p> <p>3/22/12 at 2:35 p.m., room 209's window curtain was off of two hooks.</p> <p>3/22/12 at 2:44 p.m., room 213's bathroom floor had stains around the baseboard and there were scuffs on the wall above the cove board.</p> <p>3/22/12 at 2:45 p.m., room 217's wall was marred behind the window bed measuring 1 1/2 inch irregularly open and cracked. The bathroom floor around the cove board had build up of dust and debris and under the sink in the corner and the dry wall was peeling under the sink.</p> <p>3/22/12 at 3:48 p.m., room 215's bathroom had a build up of dust and debris around the cove board. There were gaps in the tiles around the toilet, with a dark substance build up in the gaps. The tile floor had scattered areas of grayish discoloration, gaps between the tiles with a build up of debris in the gaps.</p>		<p>4/13/2012. These areas are also monitored by the monthly TEL's checklist, any issues identified by this checklist will be added to the resident room inspection QA and will be completed by the maintenance department (Attachment G - Maintenance QA – Room Inspections). The areas identified as needing cleaning are rooms 211, 213, 215, 217, 104, 108, 112, 114, 115 and the fire doors between both the 100 and 200 halls have been added to the daily housekeeping checklist. This will also continue to be on the Housekeeping monthly QA and any issues will be added to the summary sheet for completion (Attachment H – Housekeeping safety and services review). To ensure this deficient practice will not continue the facility will monitor floor maintenance and condition, maintain a regular cleaning schedule focusing on the dust and debris in the corners, repair the malfunctioning window curtain and make repairs to walls and cove bases. This will be monitored by the Maintenance Supervisor on his monthly TELs checklist (Attachment C Tels Checklist) and by the Housekeeping supervisor on her daily housekeeping schedule (Attachment D – Housekeeping daily Checklist). Any flooring areas identified to be in poor condition and/or require replacement will be added to the</p>				

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	<p>3/23/12 at 8:14 a.m., room 216's heating unit had a gap at one end and peeling paint above the unit.</p> <p>3/23/12 at 8:28 a.m., room 210's bathroom floor had several tiles with gaps and there was a dark substance in the gaps between the tiles and the toilet base had no caulking. There was a saucer size discolored tan area on the ceiling and a cracked area in the ceiling near the curtain rod.</p> <p>3/26/12 at 11:35 a.m., room 206 had a cracked area approximately 12 inches above the cove board between the heating unit and the shelving unit, below the exterior window.</p> <p>100 Hall:</p> <p>3/22/12 at 10:12 a.m., room 108's bathroom floor had a build up of dust and debris at the cove board, especially around the corners.</p> <p>3/22/12 at 10:22 a.m., room 115's bathroom floor had a build up of dust and debris at the cove board. There was also a build up of dust and debris at the corners of the entry way door frame to the room.</p> <p>3/22/12 at 10:37 a.m., room 114 had</p>		<p>replacement schedule that will be maintained by the administrator (Attachment E – Floor Replacement Schedule). Any areas that require repair or cleaning will be scheduled and completed by the maintenance and housekeeping departments. All findings will be addressed and reviewed in the 4/19/2012 Quality Assurance meeting.</p> <p>Completion date: The floor tiles are scheduled to be replace on 5/15/2012 – 5/18/2012, which is the earliest date the contractor can obtain the supplies and complete the job; all other repairs and cleaning will be completed by 4/27/2012.</p>				

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	<p>a build up of dust and debris at the corners of the entry way door frame and around the cove board in the bathroom.</p> <p>3/22/12 at 10:42 a.m., room 104's bathroom floor had build up of dust and debris around the cove board. There was also a build up of dust and debris at the corners of the entry way door frame of the room.</p> <p>3/22/12 at 12:43 a.m., room 112's bathroom had a build up of dirt and debris around the cove board.</p> <p>During the environmental tour on 3/27/12 at 1 p.m. with the Maintenance Director, Housekeeping Supervisor and the Administrator the following was observed:</p> <p>In the therapy room, the bathroom door's trim was pulled away from the frame on the right side of the door.</p> <p>The 100 and 200 hall fire doors had build up of dust and debris in the corners behind the doors.</p> <p>During interview with the Housekeeping Supervisor during the tour, she indicated the facility had been working the floors and just completed the floor around the nurses</p>			

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	<p>station and indicated they needed to work on the rooms and the hallways.</p> <p>During interview with the Housekeeping Supervisor on 3/28/12 at 12:40 p.m., she indicated the dirty floors were identified in the Quality Assurance Program on 3/1/12 but there was no schedule to follow as to how the floors would get cleaned.</p> <p>3.1-19(f)</p>			

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F0332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observations, record reviews, and interview, the facility failed to ensure it remained free of a medication error rate of 5 % or greater for 7 of 50 opportunities during 4 of 7 nursing staff observed and for 5 of 17 residents observed during medication pass observation. The medication error rate was 14%. (Resident #'s 45, 55, 30, 66, and 33) (LPN #'s 1, 2, and 4; RN #5)</p> <p>Findings include:</p> <p>1. On 3/26/12 at 4:47 p.m., medication pass was observed. LPN #1 indicated Resident #45's blood sugar result was 208 and required insulin coverage. After LPN #1 prepared the 5 units of Novolog insulin (diabetes mellitus), she was observed to administer the insulin coverage at 4:56 p.m. The resident was observed to receive his meal tray at 5:43 p.m.</p> <p>Resident #45's medications were reconciled on 3/26/12 at 5:25 p.m. The physician order was Novolog Insulin subcutaneously (subq) weight</p>	F0332	F 332 The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation. All residents in the facility have the potential to be affected by this deficient practice but residents #45, #55, #30, #33 had no negative outcomes from the observed medication pass concerns of 3/26 and 3/27/ 2012. In order to prevent this deficient practice from occurring in the future the facility's Inservice Director conducted training with all nurses on the medication pass procedure, which included administering medication at the correct time, the correct amount/dose, dissolving/mixing with correct amounts of fluids as ordered and the requirement of nursing supervision until medication administration is complete. Education was provided on importance of following physician orders and adhering to timed orders/stopping medications as ordered. In addition to this, medication administration/med pass skill check-offs are to be completed with all nurses which included specific training on short acting	04/27/2012			

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	<p>based sliding scale which included, but was not limited to, blood sugar 200 to 224 = 5 units.</p> <p>On 3/28/12 at 7:55 a.m., Unit manager #6 indicated the Nursing 2012 Drug Handbook was one of the sources utilized for medication information. This Nursing 2012 Nursing Drug Handbook for the medication, Novolog, (control of hyperglycemia) indicated the subq administration of Novolog should be given 5 to 10 minutes before the start of a meal.</p> <p>2. On 3/26/12 at 5:02 p.m., medication pass was observed. After LPN #1 was observed to prepare Resident #55's medication, Spiriva (Chronic Obstructive Pulmonary Disease), she handed the resident her Spiriva handheld device. No instructions were given as the resident was observed to take 1 breath and then, a second breath from the device. LPN #1 then asked the resident if she had heard any rattling while using the device. When Resident #55 indicated she had not heard any rattling, LPN #1 gave the hand held device back to the resident. She then instructed her to take another breath and listen for the rattle. The resident took another</p>		<p>insulin and the timing of administering prior to meals (Attachment A – Skill Check Off the Medication Pass). This training also included the manufacturer's instructions for administration of spiriva and nurses were instructed on what to tell the resident prior to and during administration of spiriva. A spiriva skill check-off is to be completed with each nurse (Attachment I – Administration of Spiriva) Nursing is responsible for ensuring the medication is administered correctly according to physician's orders and manufacturer's recommendations. This will be completed by 4/27/2012. The med pass skills check offs will be completed on 50% of the nurses every month for six months and thereafter each nurse a minimum of 2 times per year. All issues will be addressed immediately with involved staff and reviewed in the monthly Quality Assurance meeting.</p> <p>Completion date: 4/27/2012</p>				

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	<p>breath and gave it back to the nurse. No further information/inquiry was indicated related to the Spiriva handheld device as the LPN #1 put the handheld device away.</p> <p>Resident #55's medications were reconciled on 3/26/12 at 5:30 a.m. The physician order was Spiriva 18 micrograms/capsule metered dose inhaler (MDI) administer 1 capsule daily at 4 p.m. for chronic obstructive pulmonary disease.</p> <p>The Spiriva HandiHaler "Instructions for Use" policy was provided by the Director of Nursing (DON) on 3/28/12 at 9:55 a.m. This current policy indicated the following:</p> <p>...Step 4. Taking your full daily dose (2 inhalations from the same SPIRIVA capsule):</p> <p>Breathe out completely in 1 breath, emptying your lungs of any air....Important: Do not breathe into your HandiHaler device.</p> <p>With your next breath, take your medicine:</p> <p>* Hold your head in an upright position while you are looking straight ahead....</p>			

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	<p>* Raise your HandiHaler device to your mouth in a horizontal position Do not block the air intake vents.</p> <p>* Close your lips tightly around the mouthpiece.</p> <p>* Breathe in deeply until your lungs are full. You should hear or feel the SPIRIVA capsule vibrate (rattle)....</p> <p>* Hold your breath for a few seconds and, at the same time, take your HandiHaler device out of your mouth.</p> <p>* Breathe normally again.</p> <p>The rattle tells you that you breathed in correctly. If you do not hear or feel a rattle, see the section, [If you do not hear or feel the SPIRIVA capsule rattle as you breathe in your medicine.]</p> <p>To get your full daily dose, you must again, breathe out completely... and for a second time, breathe in... from the same SPIRIVA capsule.</p> <p>...Remember: To get your full medicine dose each day, you must breathe in 2 times from the same SPIRIVA capsule. Make sure you breathe out completely each time before you breathe in from your HandiHaler device."</p> <p>3. On 3/27/12 at 8:20 a.m., medication pass was observed. As</p>						

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	<p>LPN #2 prepared Resident #55's oral medications, she indicated she had missed the medication, Promethazine (nausea) scheduled for 7 a.m. This same medication was given at 8:20 a.m. with the resident's scheduled 8 a.m. oral medications.</p> <p>Resident #55's medications were reconciled on 3/27/12 at 9:25 a.m. The physician order was Promethazine 12.5 milligrams 1 by mouth daily at 7:00 a.m. for nausea.</p> <p>4. On 3/27/12 at 8:52 a.m., medication pass was observed. RN #5 was observed to given Resident #30 her oral medications, which included but were not limited to, diclofenac sodium (Voltaren) (antiarthritic).</p> <p>The resident's medications were reconciled on 3/27/12 at 9:35 a.m. The physician order was Voltaren 50 mg 1 po for 5 days for right foot pain.</p> <p>On 3/27/12 at 10:13 a.m. during an interview, RN #5 indicated this was the 6th day for the medication Voltaren and should had not been given.</p> <p>5. On 3/27/12 at 9:10 a.m., medication pass was observed. RN</p>						

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	<p>#5 was observed to prepare Resident #66's oral medications, which included tramadol (pain), Diovan (hypertension), and Klor-con (potassium replacement). Upon entering the resident's room, RN #5 placed the resident's pills on her bedside table. Next, RN #5 indicated she needed a spoon to assist the resident with her Klor-con medication and left the room with the medications left at the resident's bedside. Resident #66 was observed to take one of her pills from her medication cup on the bedside table during RN #5's absence.</p> <p>The resident's medications were reconciled on 3/27/12 at 9:35 a.m. and indicated an additional scheduled medication, Citalopram 10 mg (depression), to be given 1 tablet by mouth at 8:00 a.m.</p> <p>At 3/27/12 at 10:35 a.m. during an interview, RN #5 indicated she had missed and had not given the medication, Citalopram, which was then given at this time.</p> <p>6. On 3/27/12 at 12:47 p.m., medication pass was observed. LPN #4 was observed to prepare Resident #33's oral medications. LPN #4 proceeded to mix 1 tablet of alka</p>						

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	<p>seltzer gold in a glass of water from the top of the medication cart. This liquid mixture medication was given to the resident.</p> <p>On 3/27/12 at 1:05 p.m. during an interview, LPN #4 indicated the cup he had used for Resident #33's tablet was 120 cc (4 ounces) and should had been mixed with 240 cc (8 ounces) as ordered.</p> <p>On 3/27/12 at 3:55 p.m., Resident #33's medications were reconciled. The physician order was sodium bicarb (bicarbonate) effervescent 1 tablet dissolve in 8 oz of water and give by mouth after each meal for an upset stomach.</p> <p>7. The "Medication Administration Procedure" policy was provided by the DON on 3/28/12 at 8:28 a.m. This current policy indicated the following:</p> <p>"Administering Oral Medications ...6. Read the administration record and select the proper medication from the resident's med stock. ...15. Ensure (sic) that the resident receives the med at the correct time- 60 min before or after scheduled time. ...21. Remain with the resident until</p>						

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	<p>each medication is swallowed. Never leave medication with the resident....."</p> <p>The "Physician Order Transcription Procedure" policy was provided by the DON on 3/28/12 at 9:42 a.m. This current policy indicated the following:</p> <p>"1. Policy: A. It is the policy of Miller's Merry to ensure that physician orders are transcribed and maintained in a manner that ensures safety upon administration.</p> <p>2. Procedure: Physician orders must be taken and transcribed by a licensed nurse. ...G. Transcribing orders onto the current month's administration record: I. New orders- ...* Medications ordered for a specific time frame i.e. X (times) 7 days, shall be added to the MAR (medication administration record) and will be numbered off or x'd (checked) off to ensure only the amount ordered are given....."</p> <p>3.1-48(c)(1) 3.1-25(b)(9)</p>				

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F0441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observations, interviews, and record review, the facility failed to</p>	F0441	F 441	04/27/2012	

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	<p>ensure infection control practices were followed related to cleaning of equipment and handwashing/glove use during medication pass for 4 of 7 nursing staff observed and for 8 of 17 residents observed during medication pass. This had the potential to impact 48 of 48 residents residing in the facility. (LPN #'S 1, 4, and 3; RN #5) (Resident #'s 6, 70, 45, 47, 49, 62, 30, and 66)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 3/26/12 at 11:32 a.m., medication pass was observed. First, LPN #3 was observed to administer Resident #6's eye medication without donning a pair of gloves. Next, as Resident #6's nebulizer treatment was to be administered, the nebulizer machine and bagged mask were located at the end of the resident's bed. After Resident #6 completed her nebulizer treatment, the nebulizer machine remained at the end of the resident's bed as the nebulizer mask was bagged and returned to the end of her bed. On 3/26/12 from 11:55 a.m. to 12:10 p.m. during medication pass observation, the following was observed: 		<p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation. All residents in the facility have the potential to be affected by this deficient practice but no negative outcomes were observed for any of the identified residents. In order to prevent this deficient practice from occurring in the future the facility's Inservice Director conducted training with all nurses on the medication pass procedure, which included handwashing with administration of meds and when gloves should be worn. Education was provided on the importance of not cross-contaminating equipment and supplies. A review of how to clean the glucometers and handwashing was completed with this training (Attachment J). In addition to this, LPN #3 received additional 1 on 1 training with Inservice Director that included eye drop administration, proper use of nebulizer equipment and cross contamination of equipment when placed on residential linens. LPN #4 received additional 1 on 1 training with Inservice Director on importance of not cross-contaminating equipment and supplies, in regards to placement of medication books and was also further re-educated on cleaning of glucometers with a 1 on 1 skill check completed on glucometer</p>				

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	<p>Resident #70's blood sugar was checked. As LPN #4 prepared the glucometer, he was observed to place the glucometer on the resident's leg as he obtained the blood specimen and then, the blood sugar results. After returning to his medication cart, LPN #4 was observed to use a disinfectant cloth and cleansed the glucometer for 45 seconds.</p> <p>Resident #45's blood sugar was checked. After completing the glucometer check, LPN #4 cleansed the glucometer with the disinfectant cloth for 20 seconds and left it on top of the medication cart to dry.</p> <p>On 3/26/12 at 12:56 p.m. during medication pass, LPN #4 was observed to bring the 100 Medication (med) book into Resident #70's room. This book was placed on the resident's unmade bed as he checked the insulin coverage. After the resident's insulin was given, LPN #4 returned the medication book to the med cart. No cleansing of the medication book was observed.</p> <p>On 3/26/12 at 4:40 p.m., the disinfecting wipe container in the medication cart was reviewed. The information indicated when</p>		<p>cleaning. LPN #1 was educated 1 on 1 on the procedure for glove use when handling bodily fluids, specifically with blood samples obtained for glucometer use. LPN#1 was re-educated on hand washing procedure and 1 on 1 for hand washing skill check off was completed with her. RN#5 was re-educated on hand washing procedure and 1 on 1 hand washing skill check off completed with her. RN#5 also received additional training on the medication pass procedure, which included infection control measures and disposal of dropped/contaminated meds. The cleaning of glucometers check-off is to be completed with every nurse and this will be provided by Inservice Director or other designee. This will be conducted on 50% of the nurses every month for six months and thereafter each nurse a minimum of 2 times per year. In addition to this, medication administration/med pass skill check-offs are to be completed with all nurses (Attachment A – Skill Check Off the Medication Pass). This will be completed by 4/27/2012. The med pass skills check offs will be completed on 50% of the nurses every month for six months and thereafter each nurse a minimum of 2 times per year. Any issues will be addressed immediately with the involved staff member and the findings</p>		

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	<p>disinfecting, thoroughly wet pre-cleaned, hard, non-porous surface with a wipe, keep wet for 2 minutes and allow to dry. One may use as many wipes as necessary for the surface to keep wet for the 2 minutes and was to remain wet for the entire contact time. These wipes were indicated for general disinfectant wipe for equipment.</p> <p>On 3/27/12 at 1:05 p.m. during an interview, LPN #4 indicated the glucometer should be cleansed with the disinfectant cloth for 2 minutes with a timer in the medication cart for use. He also indicated he should not have placed the medication book, which he had carried into the resident's room, on the resident's bed.</p> <p>3. On 3/26/12 at 4:34 p.m. during medication pass observation, LPN #1 was observed to complete Resident #49's accucheck. With ungloved hands, she used the lancet on one of the resident's right hand fingers and obtained a blood sample. As she prepared to apply the blood sample to the glucometer, the glucometer shut off. Next, LPN #1 returned to her medication cart and obtained a new strip for the glucometer and reset the glucometer. LPN #1 then donned a</p>		<p>reviewed in the Quality Assurance meeting.</p> <p>Completion Date: 4/27/2012</p>		

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	<p>right hand glove only and completed the accucheck on the same pricked finger pressing on the finger to obtain a second blood specimen for the glucometer.</p> <p>4. On 3/26/12 at 4:47 p.m. during medication pass observation, LPN #1 was observed to administer Resident #45's insulin in his left lower abdomen. LPN #1 was then observed to handwash for 15 seconds.</p> <p>On 3/27/12 at 3:20 p.m. during an interview, LPN #1 indicated one should handwash for 20 seconds.</p> <p>5. On 3/27/12 from 8:46 a.m. to 9:00 a.m. during medication pass observation with RN #5, the following was observed:</p> <p>As RN #5 was observed to prepare resident #62's medications, one of the oral medications fell on the top of the medication cart. RN #5 was observed to use the medication cap and a piece of paper to remove the pill from the medication cart top to the medication cup with the rest of the resident 's oral medications.</p> <p>After administering Resident #62's medication, RN #5 was observed to handwash for 15 seconds.</p>				

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	<p>After Resident #30's medications were administered, RN #5 was observed to handwash for 15 seconds.</p> <p>After assisting an unidentified resident, whose personal alarm was sounding, RN #5 was observed to handwash for less than 10 seconds. RN #5 then proceeded to administer Resident #66's oral medications.</p> <p>6. On 3/27/12 from 1:10 p.m. to 2:13 p.m. during medication pass observation, the following was observed:</p> <p>In preparation and after Resident #47's nebulizer treatment was completed, RN #5 was observed each time to handwash for 10 seconds and turn the water off with her wet hands before drying her hands.</p> <p>In preparation and after Resident #70's nebulizer treatment was completed, RN #5 was observed each time to handwash for 10 seconds and turned the water off</p> <p>On 3/27/12 at 3:30 p.m. during an interview, RN #5 indicated one should handwash by saying "Happy Birthday" 2 times. She also indicated one</p>				

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	<p>should turn the water off after washing one's hands with a paper towel.</p> <p>On 3/28/12 at 3:25 p.m. during an interview, the Administrator indicated all 48 residents received medications from the facility.</p> <p>7. The "Hand Washing and Hand Asepsis" policy was provided by the Director of Nursing (DON) on 3/28/12 at 8:28 a.m. This current policy indicated the following:</p> <p>"1. POLICY: * To provide protection for resident and staff when performing direct care procedure. To ensure that hands remain clean so as to assist in maintenance of a clean environment and assist in the prevention of and the transmission of disease and infection.</p> <p>2. PROCEDURE: ...D. Angle arms down holding hands lower than elbows. Wet hands and wrists. Rub vigorously for at least 20 seconds... ...F. Rinse hands thoroughly, keeping them downward, allow the water to run from the wrist to the fingers. G. Pat hands dry with paper towel. H. Turn off faucets with paper towel...</p> <p>3. Key Procedural Points:</p>						

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	<p>A. SPECIFIC TIMES HANDS MUST BE WASHED: ...II. Before and after direct resident contact... ...9. HAND HYGIENE * Hand hygiene has been cited as the single most important practice to reduce the transmission of infectious agents in health care settings...."</p> <p>The "Blood Glucose Monitoring" policy was provided by the Administrator on 3/28/12 at 9:46 a.m. This current policy indicated the following: "...PROCEDURE ...G. Wash hands and apply gloves....."</p> <p>The "Cleaning of Glucometer" policy was provided by the DON on 3/28/12 at 8:28 a.m. This current policy indicated the following: "1. PURPOSE: * To maintain infection control between resident use. 2. PROCEDURE: A. After completing a blood sugar on one resident and before doing a blood sugar on another resident, use a commercial disinfectant wipe...and completely wipe down the glucometer so it is visibly wet...."</p>			

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	<p>...C. Follow manufacturer's instructions related to length of time to disinfect before reusing. Air dry time is typically around 30 seconds, so you must rewet the meter or wrap the wet wipe around the meter after wiping it down to ensure the proper contact time is achieved as directed by the manufacturer....."</p> <p>3.1-18(l)</p>			

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F0520 SS=C	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview, the facility failed to identify and implement a plan of action related to room moves within the facility. This deficient practice impacted 1 of 1 resident reviewed who met the criteria for room transfers (Resident #33). This deficiency had the potential to impact 48 of 48 residents residing in the facility.</p> <p>Findings Include:</p>	F0520	F 520 The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation. All residents in the facility have the potential to be affected by this deficient practice but no negative outcomes were observed for any of the identified residents affected by this deficiency. The facility Quality Assurance and Improvement program was re-educated to all	04/27/2012	

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	<p>During a 3/28/12, 10:15 a.m. interview, the Administrator was questioned regarding the QAA process and the review of resident room moves within the facility and concerns with Resident #33. The Administrator indicated the facility had not identified a problem with room moves. He indicated he believed there was a tool completed by the Social Service Director. The results of the tool are brought to the QAA meetings.</p> <p>During a 3/28/12, 12:30 p.m., interview, the Administrator indicated the tool is reviewed quarterly and the tool would be reviewed at the March 2012 QAA quarterly meeting.</p> <p>During a 3/28/12, 1:15 p.m., interview the Administrator indicated the Social Service Director had not been able to attend the December 2011 quarterly QAA meeting and her statistics were not reviewed at the meeting; therefore the concerns with Resident #33 had not been identified. He indicated the tool should be reviewed when the Social Service Director cannot attend.</p> <p>3.1-52(b)(2)</p>		<p>committee members on 4/13/12 by the administrator. All involved staff were given a copy of the policy and procedure of the Quality Assurance and Improvement Program and the purpose and process was discussed. Each staff member on the Quality Assurance committee will be responsible to submit all problem logs and audit tools to the coordinator of the committee prior to the meeting if unable to attend in person. The administrator will monitor for compliance on an ongoing monthly basis and will address and issues immediately.</p> <p>Completion date: 4/27/2012</p>		