

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/07/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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F000000	<p>This visit was for the Investigation of Complaint IN00134991.</p> <p>Complaint IN00134991 - -Substantiated. Federal and state deficiencies related to the allegations are cited at F222 and F425.</p> <p>Survey dates: November 5, 6 and 7, 2013</p> <p>Facility number: 000018 Provider number: 155053 AIM number: 100273930</p> <p>Survey team: Penny Marlatt, RN, TC Charles Stevenson, RN</p> <p>Census bed type: SNF: 10 SNF/NF: 48 Residential: 19 Total: 77</p> <p>Census payor type: Medicare: 7 Medicaid: 48 Other: 22 Total: 77</p> <p>Sample: 4</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 11/12/13 by Suzanne Williams, RN</p>				

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F000222 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS</p> <p>The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on interview and record review, the facility failed to ensure a resident was not medicated with a benzodiazepine three or more hours prior to its time for administration for the convenience of a staff member as a means to limit the resident's frequent use of the call light for 1 of 4 residents reviewed for medication administration in a sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 11-5-13 at 6:00 p.m. Her diagnoses included, but were not limited to anoxic brain damage, anxiety, depression, quadriplegia, history of pneumonia, tracheostomy and gastrostomy.</p> <p>Review of Resident #A's most recent Minimum Data Set (MDS) assessment, dated 8-28-13, indicated the resident is moderately cognitively impaired with a feeding tube in which she receives more than 50% of her</p>	F000222	F222 We respectfully request paper compliance in order to correct these deficient practices. Resident A was monitored and assessed following the early administration of Klonopin with no negative effects noted. RN #1 was terminated 10.21.13. All alert and oriented and reliable residents were interviewed to determine if they have received medication in a timely manner not outside of the 1 hour before or after the scheduled administration time. Medication Administration observations will occur to monitor for accuracy. All nursing staff will be in-serviced by 11.22.13 on the Policy and Procedure for Medication and Administration Procedure (Attachment #1), Psychotropic Medication Use Policy (Attachment #2) and the Policy and Procedure for Behavior Assessment and Management (Attachment #3). Corrective action will be QA monitored using the Medication Administration Monitoring Tool (Attachment #4). This QA tool will be used by the DON or designee daily X 1 week, weekly X 4 weeks and monthly X 6 months to ensure the residents	11/22/2013			

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	<p>caloric intake daily. An updated cognition assessment, dated 10-12-13, indicated she is cognitively intact. A physician's progress note, dated 9-26-13, indicated in the last year, the resident's ability to sign, lip read and use facial movements to make her wishes known; her actions and decisions are reasonable and appropriate. He indicated she is able to decide about ADL's (activities of daily living) and medical interventions.</p> <p>Review of Resident #A's physician orders indicated an order for Klonopin 0.5 mg (milligrams) 2 tablets (1 mg) daily at 8:00 p.m., with a time change noted on the Medication Administration Record (MAR) to reflect the administration time to be 11:00 p.m.</p> <p>A "Medication and Treatment Error Report" was provided by the Director of Nursing (DON) on 11-6-13 at 4:05 p.m. This form indicated on 10-2-13 at approximately 7:15 p.m., RN #1 administered Klonopin 1 mg, instead of the scheduled time at 11:00 p.m. In a written statement from the DON, that was undated, it indicated RN #1 had indicated in interview "the resident was anxious and restless and he thought he would just give her the Klonopin early to ease that." It</p>		<p>are receiving their medication during the allowable time frame and for the diagnosis it was intended. This process will be monitored using the Quality Improvement Audit Tool Medication Administration Monitoring Tool (Attachment #4). The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented. Date of compliance 11.22.13.</p>				

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	<p>indicated RN #1 was aware of acceptable time parameters in which medications can be administered. It indicated he was educated on medication administration time frames.</p> <p>A "Disciplinary Detail" report was provided by the DON on 11-6-13 at 4:06 p.m. This document was dated 10-21-13. It indicated RN #1 began employment with the facility on 10-16-13. It indicated, "you have displayed poor nursing skills by administering a medication to a resident 4 to 5 hours [sic] earlier than ordered and stating the purpose of administering the medication early was because this resident was call light crazy and you would put an end to that. (Resident received Klonopin outside the allotted time frame of medication administration.) RN #1's handwritten response, date 10-21-13, indicated he had administered the medication early related to the resident's anxiety and the nurse's inability to reach the resident's spouse. It indicated, "When asking the co-nurse as to giving medications early, she replied, 'It's been done before.'" The document indicated RN #1 was terminated from employment on 10-21-13 related to "Failure to Satisfactorily Complete Adjustment</p>				

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	<p>Period - discharge for misconduct/poor performance."</p> <p>In interview with the DON on 11-7-13 at 3:15 p.m., during the exit conference for the survey, she indicated the facility had only addressed the error with giving the medication too early as there was no harm identified to the resident. She indicated she could understand additional concerns, "because the nurse was too stupid to keep his mouth shut." When queried if RN #1 had utilized a prn (as needed) order for Ativan 0.5 mg every 6 hours as needed for anxiety or contacted the physician for guidance, she indicated he did not do so.</p> <p>On 11-5-13 at 3:21 p.m., the DON provided a copy of the facility's policy on Resident's Rights. This policy indicated, "...The resident has the right to be free from any physical or chemical restraints imposed for the purposes of convenience..."</p> <p>This Federal tag relates to Complaint IN00134991.</p> <p>3.1-3(w) 3.1-26(m)</p>			

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure 1 of 4 residents in a sample of 4 did not have medication administered out of the normal administration time frames of one hour before or one hour after the scheduled time frames and facility staff who administer medications do not leave medications unattended during 1 of 2 medication administration observations. (Resident #A and #D)</p> <p>Findings include:</p>	F000425	F425 Resident A was monitored and assessed following the early administration of Klonopin with no negative effects noted. RN #1 was terminated 10.21.13. LPN #2 was re-educated on the Policy and Procedure for Medication Administration Procedure with a focus on the importance of ensuring medication is secure and not left unattended (Attachment #1). All alert and oriented and reliable residents were interviewed to determine if they have received medication in a timely manner not outside of the 1 hour before or after the scheduled administration time. Medication Administration	11/22/2013

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	<p>1. Resident #A's clinical record was reviewed on 11-5-13 at 6:00 p.m. Her diagnoses included, but were not limited to anoxic brain damage, anxiety, depression, quadriplegia, history of pneumonia, tracheostomy and gastrostomy.</p> <p>Review of Resident #A's physician orders indicated an order for Klonopin 0.5 mg (milligrams) 2 tablets (1 mg) daily at 8:00 p.m., with a time change noted on the Medication Administration Record (MAR) to reflect the administration time to be 11:00 p.m.</p> <p>A "Medication and Treatment Error Report" was provided by the Director of Nursing (DON) on 11-6-13 at 4:05 p.m. This form indicated on 10-2-13 at approximately 7:15 p.m., RN #1 administered Klonopin 1 mg, instead of the scheduled time at 11:00 p.m. In a written statement from the DON, that was undated, it indicated RN #1 had indicated in interview "the resident was anxious and restless and he thought he would just give her the klonopin early to ease that." It indicated RN #1 was aware of acceptable time parameters in which medications can be administered. It indicated he was educated on medication administration time</p>		<p>observations will occur to monitor for accuracy. No other residents were affected by this deficient practice of leaving medication unattended. Other residents have the potential to be affected by this practice if they have medication that is removed from a secured cart and left unattended. Medication Administration observations will occur to monitor for accuracy. All Nursing staff will be in-serviced by 11.22.13 on the Policy and Procedure for Medication and Administration Procedure (Attachment #1), Psychotropic Medication Use Policy (Attachment #2) and the Policy and Procedure for Behavior Assessment and Management (Attachment #3). All staff were re-educated on the Medication Administration Procedure (Attachment #1) with a focus on the importance of ensuring medication is secure and not left unattended. Corrective action will be QA monitored using the Medication Administration Monitoring Tool (Attachment #4). This QA tool will be used by the DON or designee daily X 1 week, weekly X 4 weeks and monthly X 6 months to ensure the residents are receiving their medication during the allowable time frame and for the diagnosis it was intended and to ensure medication is secured inside a locked medication cart when</p>		

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	<p>frames.</p> <p>A "Disciplinary Detail" report was provided by the DON on 11-6-13 at 4:06 p.m. This document was dated 10-21-13. It indicated RN #1 began employment with the facility on 10-16-13. It indicated, "you have displayed poor nursing skills by administering a medication to a resident 4 to 5 hours [sic] earlier than ordered and stating the purpose of administering the medication early was because this resident was call light crazy and you would put an end to that. (Resident received Klonopin outside the allotted time frame of medication administration.) RN #1's handwritten response, date 10-21-13, indicated he had administered the medication early related to the resident's anxiety and the nurse's inability to reach the resident's spouse. It indicated, "When asking the co-nurse as to giving medications early, she replied, 'It's been done before.'" The document indicated RN #1 was terminated from employment on 10-21-13 related to "Failure to Satisfactorily Complete Adjustment Period - discharge for misconduct/poor performance."</p> <p>In interview with the DON on 11-7-13 at 3:15 p.m., during the exit</p>		<p>unattended and/or out of sight of the administering Nurse. This process will be monitored using the Quality Improvement Audit Tool Medication Administration Monitoring Tool (Attachment #4). The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented. Date of compliance 11.22.13.</p>				

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	<p>conference for the survey, she indicated the facility had only addressed the error with giving the medication too early as there was no harm identified to the resident. When queried if RN #1 had utilized a prn (as needed) order for Ativan 0.5 mg every 6 hours as needed for anxiety or contacted the physician for guidance, she indicated he did not do so.</p> <p>2. During a medication administration observation with LPN #2 on 11-5-13 at 8:30 p.m., LPN #2 was observed to prepare medications for Resident #D. As she prepared the medications, she sat the containers of the medications on top of the medication cart. Those medications which sat on top of the medication cart included the following:</p> <ul style="list-style-type: none"> -metoprolol tartrate 25 mg (milligrams) 1/2 tablet. -Keppra 250 mg. -docusate sodium 100 mg. -Aggrenox 25/200 mg. -simvastatin 80 mg. -Stalevo 50 mg. -gabapentin 800 mg. -buspirone 10 mg. -Abilify 5 mg. <p>Upon completion of preparing medications for Resident #D, she had placed 8 full tablets and 1 half-tablet</p>			

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	<p>of medication into a medication cup, locked the medication cart, and knocked once on Resident #D's door in preparation to enter Resident #D's room. LPN #2 was then queried as to if she needed to address any other concerns prior to entering the resident's room. She indicated she was nervous and forgot to replace the medications into the medication cart. She then placed all medications listed above into the medication cart and locked the medication cart prior to resuming her medication administration.</p> <p>On 11-6-13 at 4:05 p.m., the Director of Nursing provided a facility policy related to medication administration. This policy indicated, "...Lock the medication cart before leaving it. Transport the medications to the resident and keep in sight at all times. Ensure the resident receives the med [sic] at the correct time- 60 min [sic] before or after the scheduled time..."</p> <p>This Federal tag relates to Complaint IN00134991.</p> <p>3.1-25(b) 3.1-25(b)(1)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2013

FORM APPROVED

OMB NO. 0938-0391

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