

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155049	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/14/2011
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 S COUNTY FARM RD WARSAW, IN46580
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F0000	<p>This visit was for the Investigation of Complaint IN00097605.</p> <p>Complaint IN00097605-Substantiated, Federal/State deficiencies related to the allegation are cited at F282 and F332.</p> <p>Survey Dates: October 13 &amp; 14, 2011</p> <p>Facility number: 000017 Provider number: 155049 AIM number: 100273830</p> <p>Survey team: Angela Strass, RN TC Sue Brooker, RD Rick Blain, RN</p> <p>Census bed type: SNF: 19 SNF/NF: 84 Total: 103</p> <p>Census payor type: Medicare: 22 Medicaid: 64 Other: 17 Total: 103</p> <p>Sample: 6 Supplemental Sample: 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=E	<p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</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 observation, interview and record review the facility failed to follow physician orders for administering 8:00 a.m. medications timely for 13 of 13 residents observed. (#A, B, C, D, E, F, G, H, I, J, K L, AND M)</p> <p>Findings include:</p> <p>Observation of medication pass on 10/14/11 at 9:00 a.m. with nurse #16 indicated the following residents did not receive their medications as ordered by the physician.</p> <p>1. Resident (A) received her medications at 9:30 a.m. Review of physician orders indicated the following medications were to be given at 8:00 a.m.</p> <p>Based on observation, interview and record review the facility failed to follow physician orders for 8:00</p> <p>Atenolol 12.5 milligrams at 8:00 a.m. Diltiazem 180 milligrams at 8:00 a.m. Furosimide 80 milligrams at 8:00 a.m. Isosorb Mono ER 60 milligrams at 8:00 a.m. Klor-Con 10 ER 10 milequivalents at 8:00</p>	F0282	<p>This facility respectfully requests Paper Compliance consideration for this Plan of Correction. Residents A through M did not experience any adverse effects from the untimely administration of routine oral medications. All residents in the facility have the potential to be affected by this finding. Per current facility policy &amp; pharmacy medication administration guidelines, oral medications may be administered within the parameters of 60 minutes prior to 60 minutes after the ordered medication administration time. In order to meet this timeframe, and to ensure the timely resident receipt of medications, the time frames for medication administration have been adjusted. A recent change in resident meal service times, effective 9/19/11, was a factor with the findings related to the untimely oral medication administration &amp; untimely medication administration is not the normal practice of this facility. QA auditing of new meal time changes &amp; medication administration times were being reviewed weekly by facility staff &amp; proposed time changes to</p>	11/13/2011			

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	<p>a.m.</p> <p>Mucinex 600 milligrams at 8:00 a.m. and 5:00 p.m.</p> <p>Oxycontin 15 milligrams at 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m. ,12:00 a.m. and 4:00 a.m.</p> <p>Polyeth Glycol Powder dissolve in 8 ounces of liquid at 8:00 a.m.</p> <p>Effexor 75 milligrams at 8:00 a.m. and 8:00 p.m.</p> <p>2. Resident (C) received her medications at 9:35 a.m. Review of physician orders indicated the following medications were to be given at 8:00 a.m.</p> <p>Mucinex 600 milligrams at 8:00 a.m. and 5:00 p.m.</p> <p>Protonix 40 milligrams at 8:00 a.m.</p> <p>Aspirin 81 milligrams at 8:00 a.m.</p> <p>Bumex 1 milligram at 8:00 a.m.</p> <p>Cardizem CD 120 milligrams at 8:00 a.m.</p> <p>Lisinopril 20 milligrams at 8:00 a.m.</p> <p>3. Resident (B) received her medications at 9:40 a.m. Review of physician orders indicated the following medications were to be given at 8:00 a.m.</p> <p>Diocitic Sodium 200 milligrams at 8:00 a.m.</p> <p>4. Nurse #3 was observed to administer medications to Resident #E at 9:15 A.M.</p>		<p>medication administration was considered. No residents or responsible parties verbalized any concerns about untimely medication administration. Individually &amp; collectively, all nursing staff will be inserviced with education on timeliness of medication administration. A review of the policy on medication administration procedures will be given to each licensed nurse &amp; QMA by 11/13/11. Physician approval for medication administration times have been received for all residents (see Attachment A). Specifically timed medications will be given per physician order &amp; will be unaffected by this medication administration time change. Monitoring for accurate timeliness for medication administration will be completed using the QA/QI audit tool "Medication Pass Procedure" (see Attachment B). This audit will be completed weekly for 6 weeks, then quarterly thereafter as part of the facility QA Program. The entire medication pass timeframe will be monitored for at least 1 unit, with the a different unit being monitored weekly or quarterly ongoing, according to the QA Program schedule. Any discrepancies found will be immediately addressed and/or corrected. A summary of the audit results will be compiled &amp; reviewed by the Director of Nursing, or designee, to ensure</p>		

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	<p>A review of the resident's orders indicated the following medications were to be administered at 8:00 A.M.:</p> <p>Vitamin D 1000 units at 8:00 A.M. Prednisone 5 mg (milligrams) at 8:00 A.M. Claritin 10 mg at 8:00 A.M. Ditropan 5 mg at 8:00 A.M. Glucosamine Chondroitin Sulfate 500/400 2 tabs at 8:00 A.M. Lisinopril 10 mg at 8:00 A.M. Baclofen 10 mg 2 tabs at 8:00 A.M. Calcium with Vitamin D 600 mg/400 units at 8:00 A.M.</p> <p>5. Nurse #16 was observed to administer medications to Resident #D at 9:20 A.M. A review of the resident's orders indicated the following medications were at administered at 8:00 A.M.:</p> <p>Aspirin 81 mg at 8:00 A.M. Amlodipine 10 mg at 8 A.M. Avalide 150/12.5 mg at 8:00 A.M. Calcium with Vitamin D 500 mg at 8:00 A.M. Folic Acid 1 mg at 8:00 A.M. Multaq 400 mg at 8:00 A.M. Potassium Chloride 10 meq (milliequivalents) at 8:00 A.M. Rantitidine 150 mg at 8:00 A.M. Vitamin D 3000 units at 8:00 A.M.</p>		compliance ongoing. The Director of Nursing, or designee, will be responsible.		

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	<p>6. Nurse #3 was observed to administer medications to Resident #F at 9:30 A.M. A review of the resident's orders indicated the following medications were at administered at 8:00 A.M.:</p> <p>Coreg 25 mg at 8:00 A.M. Namenda 5 mg at 8:00 A.M. Celexa 20 mg at 8:00 A.M. Multivitamin at 8:00 A.M. Amlodipine 5 mg at 8:00 A.M.</p> <p>7. Nurse #3 was observed to administer medications to Resident #G at 9:40 A.M. A review of the resident's orders indicated the following medications were at administered at 8:00 A.M.:</p> <p>Klor-Con 10 milliequivalents 7.5 milliliters at 8:00 A.M. Lasix 20 mg at 8:00 A.M. Lisinopril 20 mg at 8:00 A.M. Multivitamin at 8:00 A.M.</p> <p>8. During an observation of the Heritage Hall on 10/14/11 at 9:20 a.m., Nurse #1 was interviewed. During the interview she indicated she still had 8:00 a.m. medications to pass for six residents. At 9:28 a.m., Nurse #1 was observed to administer medications to Resident #H. A review of the resident's orders indicated the following medications were to be administered at 8:00 a.m.:</p>				

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	<p>Folic Acid 1 mg at 8:00 a.m. Lovaza 1 gm at 8:00 a.m. Metformin 500 mg at 8:00 a.m. Evista 60 mg at 8:00 a.m. Certavite 1 tab at 8:00 a.m. Omeprazole 20 mg at 8:00 a.m. Cranberry Extract 1 tab at 8:00 a.m. Vitamin D3 5000IU at 8:00 a.m. Oyster Calcium 500mg at 8:00 a.m.</p> <p>9. Nurse #1 was observed to administer medications to Resident #I at 9:30 a.m. A review of the resident's orders indicated the following medications were to be administered at 8:00 a.m.:</p> <p>Aspirin 81 mg at 8:00 a.m. Celebrex 100 mg at 8:00 a.m. Certagen Silver 1 tab at 8:00 a.m.</p> <p>10. Nurse #2 was observed to come to the medication cart at 9:31 a.m., to assist RN #1 with the passing of the 8:00 a.m. medications. At 9:34 a.m., RN #2 was observed to administer medication to Resident #J. A review of the resident's orders indicated the following medication were to be administered at 8:00 a.m.:</p> <p>Klor-Con 30 meg at 8:00 a.m. Metoprolol ER 50 mg at 8:00 a.m. Poly-Iron 150 mg at 8:00 a.m. Lisinopril 40 mg at 8:00 a.m.</p>			

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	<p>Isosorb Mono 60 mg at 8:00 a.m. Spironolactone 25 mg at 8:00 a.m. Torsemide 20 mg at 8:00 a.m. Vitamin C 500 mg at 8:00 a.m. Pantoprazole 40 mg at 8:00 a.m. Lipitor 10 mg at 8:00 a.m. Risperidone 0.25 mg at 8:00 a.m. Fluoxetine 30 mg at 8:00 a.m.</p> <p>11. Nurse #1 was observed to administer medications to Resident #K at 9:45 a.m. A review of the resident's orders indicated the following medications were to be administered at 8:00 a.m.:</p> <p>Namenda 5 mg at 8:00 a.m. Aricept 20 mg at 8:00 a.m. Norvasc 10 mg at 8:00 a.m.</p> <p>12. Nurse #1 was observed to administer medication to Resident #L at 9:46 a.m. A review of the resident's orders indicated the following medications were to be administered at 8:00 a.m.:</p> <p>Pot Chloride Micro ER 20 meq at 8:00 a.m. Furosemide 40 mg at 8:00 a.m. Nadolol 10 mg at 8:00 a.m. Omeprazole 20 mg at 8:00 a.m. Zetia 10 mg at 8:00 a.m. Gabapentine 300 mg at 8:00 a.m.</p> <p>13. Nurse #1 was observed to administer</p>				

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	<p>medication to Resident #M at 9:53 a.m. A review of the resident's orders indicated the following medications were to be administered at 8:00 a.m.:</p> <p>Lanoxin 0.125 mg at 8:00 a.m. K-Dur 20 meq at 8:00 a.m. Symbicort 160/4.5 2 puffs at 8:00 a.m. Guafenesin 600 mg at 8:00 a.m. Pradaxa 150 mg at 8:00 a.m. Lasix 20 mg at 8:00 a.m. Prilosec 20 mg at 8:00 a.m. Neurontin 100 mg at 8:00 a.m.</p> <p>The Administrator, the DON, and the Certified Dietary Manager (CDM) were interviewed on 10/13/11 at 2:45 p.m. During the interview the Administrator freely provided the QA log for the Premier Dining/Zone Dining program. The QA log indicated "...On 10/3/11, CDM met with all department heads, including unit managers, &amp; (and) asked for their input on the entire zone meal service, as each department head is assigned to at least 1 meal per week in the DR (dining room). Department heads gave their input, &amp; as a result DON stated that she was going to work on changing med pass times...."</p> <p>A current facility policy "Medication Administration Procedure", with a start date of 3/23/11, indicated "...Ensure that</p>				

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F0332 SS=E	<p>the resident receives the med at the correct time - 60 min before or after scheduled time..."</p> <p>3.1-35(g)(2)</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review the facility failed to follow physician orders for administering 8:00 a.m. medications timely for 13 of 13 residents observed, which resulted in a medication error rate of 100%. (#A, B, C, D, E, F, G, H, I, J, K, L, AND M)</p> <p>Findings include:</p> <p>Observation of medication pass on 10/14/11 at 9:00 a.m. with nurse #16 indicated the following residents did not receive their medications as ordered by the physician.</p>	F0332	Residents A through M did not experience any adverse effects from the untimely administration of routine oral medications. The error rate was time frame based & there were no errors related to omissions, wrong medication(s), wrong dose, etc. All residents within the facility have the potential to be affected by this finding. To ensure that this deficient practice does not re-occur, all nurses will be re-educated on the medication administration policy, specifically focusing on meeting the administration time frames. The facility medication administration time frames have been adjusted	11/13/2011	

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	<p>1. Resident (A) received her medications at 9:30 a.m. Review of physician orders indicated the following medications were to be given at 8:00 a.m. Based on observation, interview and record review the facility failed to follow physician orders for 8:00 Atenolol 12.5 milligrams at 8:00 a.m. Diltiazem 180 milligrams at 8:00 a.m. Furosemide 80 milligrams at 8:00 a.m. Isosorb Mono ER 60 milligrams at 8:00 a.m. Klor-Con 10 ER 10 milequivalents at 8:00 a.m. Mucinex 600 milligrams at 8:00 a.m. and 5:00 p.m. Oxycontin 15 milligrams at 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m. ,12:00 a.m. and 4:00 a.m. Polyeth Glycol Powder dissolve in 8 ounces of liquid at 8:00 a.m. Effexor 75 milligrams at 8:00 a.m. and 8:00 p.m.</p> <p>2. Resident (C) received her medications at 9:35 a.m. Review of physician orders indicated the following medications were to be given at 8:00 a.m.  Mucinex 600 milligrams at 8:00 a.m. and 5:00 p.m. Protonix 40 milligrams at 8:00 a.m. Aspirin 81 milligrams at 8:00 a.m.</p>		<p>to better accomodate timely delivery. The effectiveness of this change will be monitored weekly for a period of 6 weeks, then quarterly thereafter as part of the facility QA Program, using the "Medication Pass Procedure" QA/QI Form (see Attachment B). The entire medication pass timeframe will be monitored for at least 1 unit, with the a different unit being monitored weekly or quarterly ongoing, according to QA Program schedule. Any discrepancies found will be immediately addressed and/or corrected. A summary of the audit results will be compiled &amp; reviewed by the Director of Nursing, or designee, to ensure compliance ongoing. Director of Nursing, or designee, will be responsible.</p>		

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	<p>Bumex 1 milligram at 8:00 a.m. Cardizem CD 120 milligrams at 8:00 a.m. Lisinopril 20 milligrams at 8:00 a.m.</p> <p>3. Resident (B) received her medications at 9:40 a.m. Review of physician orders indicated the following medications were to be given at 8:00 a.m.</p> <p>Dioctic Sodium 200 milligrams at 8:00 a.m.</p> <p>4. Nurse #3 was observed to administer medications to Resident #E at 9:15 A.M. A review of the resident's orders indicated the following medications were to be administered at 8:00 A.M.:</p> <p>Vitamin D 1000 units at 8:00 A.M. Prednisone 5 mg (milligrams) at 8:00 A.M. Claritin 10 mg at 8:00 A.M. Ditropan 5 mg at 8:00 A.M. Glucosamine Chondroitin Sulfate 500/400 2 tabs at 8:00 A.M. Lisinopril 10 mg at 8:00 A.M. Baclofen 10 mg 2 tabs at 8:00 A.M. Calcium with Vitamin D 600 mg/400 units at 8:00 A.M.</p> <p>5. Nurse #16 was observed to administer medications to Resident #D at 9:20 A.M. A review of the resident's orders indicated the following medications were at</p>				

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	<p>administered at 8:00 A.M.:</p> <p>Aspirin 81 mg at 8:00 A.M. Amlodipine 10 mg at 8 A.M. Avalide 150/12.5 mg at 8:00 A.M. Calcium with Vitamin D 500 mg at 8:00 A.M. Folic Acid 1 mg at 8:00 A.M. Multaq 400 mg at 8:00 A.M. Potassium Chloride 10 meq (milliequivalents) at 8:00 A.M. Rantitidine 150 mg at 8:00 A.M. Vitamin D 3000 units at 8:00 A.M.</p> <p>6. Nurse #3 was observed to administer medications to Resident #F at 9:30 A.M. A review of the resident's orders indicated the following medications were at administered at 8:00 A.M.:</p> <p>Coreg 25 mg at 8:00 A.M. Namenda 5 mg at 8:00 A.M. Celexa 20 mg at 8:00 A.M. Multivitamin at 8:00 A.M. Amlodipine 5 mg at 8:00 A.M.</p> <p>7. Nurse #3 was observed to administer medications to Resident #G at 9:40 A.M. A review of the resident's orders indicated the following medications were at administered at 8:00 A.M.:</p> <p>Klor-Con 10 milliequivalents 7.5 milliliters at 8:00 A.M.</p>				

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	<p>Lasix 20 mg at 8:00 A.M. Lisinopril 20 mg at 8:00 A.M. Multivitamin at 8:00 A.M.</p> <p>8. During an observation of the Heritage Hall on 10/14/11 at 9:20 a.m., Nurse #1 was interviewed. During the interview she indicated she still had 8:00 a.m. medications to pass for six residents. At 9:28 a.m., Nurse #1 was observed to administer medications to Resident #H. A review of the resident's orders indicated the following medications were to be administered at 8:00 a.m.:</p> <p>Folic Acid 1 mg at 8:00 a.m. Lovaza 1 gm at 8:00 a.m. Metformin 500 mg at 8:00 a.m. Evista 60 mg at 8:00 a.m. Certavite 1 tab at 8:00 a.m. Omeprazole 20 mg at 8:00 a.m. Cranberry Extract 1 tab at 8:00 a.m. Vitamin D3 5000IU at 8:00 a.m. Oyster Calcium 500mg at 8:00 a.m.</p> <p>9. Nurse #1 was observed to administer medications to Resident #I at 9:30 a.m. A review of the resident's orders indicated the following medications were to be administered at 8:00 a.m.:</p> <p>Aspirin 81 mg at 8:00 a.m. Celebrex 100 mg at 8:00 a.m. Certagen Silver 1 tab at 8:00 a.m.</p>				

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	<p>10. Nurse #2 was observed to come to the medication cart at 9:31 a.m., to assist RN #1 with the passing of the 8:00 a.m. medications. At 9:34 a.m., RN #2 was observed to administer medication to Resident #J. A review of the resident's orders indicated the following medication were to be administered at 8:00 a.m.:</p> <p>Klor-Con 30 meg at 8:00 a.m. Metoprolol ER 50 mg at 8:00 a.m. Poly-Iron 150 mg at 8:00 a.m. Lisinopril 40 mg at 8:00 a.m. Isosorb Mono 60 mg at 8:00 a.m. Spironolactone 25 mg at 8:00 a.m. Torsemide 20 mg at 8:00 a.m. Vitamin C 500 mg at 8:00 a.m. Pantoprazole 40 mg at 8:00 a.m. Lipitor 10 mg at 8:00 a.m. Risperidone 0.25 mg at 8:00 a.m. Fluoxetine 30 mg at 8:00 a.m.</p> <p>11. Nurse #1 was observed to administer medications to Resident #K at 9:45 a.m. A review of the resident's orders indicated the following medications were to be administered at 8:00 a.m.:</p> <p>Namenda 5 mg at 8:00 a.m. Aricept 20 mg at 8:00 a.m. Norvasc 10 mg at 8:00 a.m.</p> <p>12. Nurse #1 was observed to administer</p>				

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	<p>medication to Resident #L at 9:46 a.m. A review of the resident's orders indicated the following medications were to be administered at 8:00 a.m.:</p> <p>Pot Chloride Micro ER 20 meq at 8:00 a.m. Furosemide 40 mg at 8:00 a.m. Nadolol 10 mg at 8:00 a.m. Omeprazole 20 mg at 8:00 a.m. Zetia 10 mg at 8:00 a.m. Gabapentine 300 mg at 8:00 a.m.</p> <p>13. Nurse #1 was observed to administer medication to Resident #M at 9:53 a.m. A review of the resident's orders indicated the following medications were to be administered at 8:00 a.m.:</p> <p>Lanoxin 0.125 mg at 8:00 a.m. K-Dur 20 meq at 8:00 a.m. Symbicort 160/4.5 2 puffs at 8:00 a.m. Guaifenesin 600 mg at 8:00 a.m. Pradaxa 150 mg at 8:00 a.m. Lasix 20 mg at 8:00 a.m. Prilosec 20 mg at 8:00 a.m. Neurontin 100 mg at 8:00 a.m.</p> <p>The Administrator, the DON, and the Certified Dietary Manager (CDM) were interviewed on 10/13/11 at 2:45 p.m. During the interview the Administrator freely provided the QA log for the Premier Dining/Zone Dining program.</p>				

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	<p>The QA log indicated "...On 10/3/11, CDM met with all department heads, including unit managers, &amp; (and) asked for their input on the entire zone meal service, as each department head is assigned to at least 1 meal per week in the DR (dining room). Department heads gave their input, &amp; as a result DON stated that she was going to work on changing med pass times...."</p> <p>A current facility policy "Medication Administration Procedure", with a start date of 3/23/11, indicated "...Ensure that the resident receives the med at the correct time - 60 min before or after scheduled time...."</p> <p>3.1-25(b)(9)</p>				