

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 0548 S 100 W HARTFORD CITY, IN 47348
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00178119.</p> <p>Complaint IN00178119 - Substantiated. Federal/State deficiencies related to allegations are cited at F 282 and F 514.</p> <p>Survey date: July 27 and 28, 2015</p> <p>Facility number: 000289 Provider number: 155576 AIM number: 100289460</p> <p>Census bed type: SNF: 6 SNF/NF: 43 Total: 49</p> <p>Census payor type: Medicare: 9 Medicaid: 32 Other: 8 Total: 49</p> <p>Sample: 4</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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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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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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 interview and record review, the facility failed to ensure physician orders and care plan interventions were followed as written for 2 of 4 residents reviewed for physician orders and care planning. (Resident D and Resident E)</p> <p>Findings include:</p> <p>1. The clinical record for Resident D was reviewed on 7/27/15 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, dementia, diabetes type 2, depressive disorder, anxiety and hypertension.</p> <p>Review of Resident D's medication orders indicated the following:</p> <p>Resident D had an order dated 9/28/14 for Novolog Solution 12 units to be injected subcutaneously two times a day for diabetes type 2. The MAR lacked any documentation for the 12:00 p.m. and the 7:00 a.m. scheduled dose on 7/22/15.</p> <p>Resident D had an order dated 6/8/15 for Novolog Solution, for diabetes type 2,</p>	F 0282	<p>F282</p> <p>The licensed nurse responsible for administering resident D's Novolog Insulin on 7/22/15 states that she did give the Novolog Insulin as ordered. The nurse states she inadvertently omitted her initials (documentation) on the medication administration record.</p> <p>The licensed nurse responsible for administering resident D's insulin on 7/27/15 states that she did give the resident Novolog Insulin 6 units as ordered based on sliding scale. The nurse states she inadvertently omitted her initials (documentation) on medication administration record.</p> <p>The licensed nurses' responsible for administering resident E's insulin on 7/25/15 and 7/26/15 state that Levemir Flex Pen Injector doses were given as ordered. The nurses state that the documentation was inadvertently omitted. The licensed nurses were counselled/educated one on one on facility policy titled Medication Administration-General Guidelines (see attachment A).</p>	08/15/2015

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	<p>per sliding scale as follows: If blood sugar is 150-200 give 4 units, 201-250 give 6 units, 251-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units, 401- 450 give 14 units, 451 give 16 units and notify MD. The MAR lacked complete documentation for the 7/22/15 scheduled dose at 11:00 a.m. The 11:00 a.m. blood sugar was documented as 207 but lacked insulin administration documentation. Resident D should have received 6 units of Novolog.</p> <p>Review of resident D's current care plan for hypo/hyperglycemia initially dated 9/6/13, indicated interventions included, but were not limited to, monitor blood sugars as ordered and give insulin as ordered.</p> <p>2. The clinical record for Resident E was reviewed on 7/27/15 at 10:08 a.m. Diagnoses for the resident included, but were not limited to, cerebrovascular accident, diabetes type 2, chronic kidney disease and depressive disorder.</p> <p>Review of Resident E's medication orders indicated the following: Resident E had an order dated 9/17/14 for Levemir Flex Pen injector 100 units/milliliters to be injected subcutaneously at bedtime for diabetes</p>		<p>The care plan was followed. The resident's did not have a negative outcome from omission of documentation.</p> <p>All residents have the potential to be affected by this practice. All current resident's medication records have been audited for omissions of documentation, no others were identified.</p> <p>Beginning on 7/29/15, licensed nurses were educated on the policy titled Medication Administration-General Guidelines (See attachment A). All licensed nurses were re-educated on Medication Administration –General Guidelines at nurses in-service on 8-6-15(See attachment B) and the new required process for ensuring this does not occur in the future.</p> <p>All licensed nurses will be responsible for reviewing their medication administration records for accuracy prior to the end of their shift and correct any inaccuracies.</p> <p>This process will be monitored by utilizing the Quality Assurance QA tool Medication Documentation review. (See attachment C). The DON or designee will audit 5x's weekly X 6 weeks, then weekly thereafter. Any non-compliance will be investigated immediately and appropriate documentation will be</p>	

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	<p>type 2. The MAR lacked any documentation for the 8:00 p.m. scheduled dose on 7/25/15 and 7/26/15.</p> <p>Review of resident E's current care plan with a focus of a potential for hypo/hyperglycemia initially dated 8/3/14, indicated interventions included, but were not limited to, monitor blood sugars as ordered and give insulin as ordered.</p> <p>During an interview on 7/27/15 at 3:52 p.m., the Director of Nursing (DON) indicated each nurse was responsible for initiating a care plan at time of admission. She indicated the interdisciplinary team would review the care plan and continue to update it as needs became known.</p> <p>During an interview on 7/28/15 at 10:15 a.m., RN #1 indicated all medications given during a shift should be signed off at the time of administration. She indicated everyone should check the MAR before they end their shift to double check everything has been signed off appropriately.</p> <p>During an interview on 7/28/15 at 1:37 p.m. LPN #2 indicated the nurses communicated the care plan needs to the nursing staff during shift change on on</p>		<p>completed. This will in turn validate that the care plan is followed for each resident. If there are omissions in the medication documentation they will be considered "medication errors" in the future and disciplinary measure may ensue for repeated omissions.</p> <p>The results of the audits and process will be reviewed by the Quality Assurance Committee at least monthly. Any recommendations will be followed.</p> <p>Systemic changes will be completed by 8/15/15.</p>				

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F 0514 SS=D Bldg. 00	<p>the 24 hour report sheet. She indicated the care plans were discussed during the shift change.</p> <p>During an interview on 7/28/15 at 4:25 p.m., the DON indicated, "Care plans are to be followed. It is expected and part of your practice. The policy may not say it out right but it is implied." No further information was provided.</p> <p>This Federal tag relates to Complaint IN00178119.</p> <p>3.1-35(g)(1)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure</p>	F 0514	F514	08/15/2015			

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	<p>documentation in resident records was complete for 3 of 4 residents reviewed for complete and accurate clinical record documentation in a sample of 4. (Resident B , Resident D and Resident E)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 7/27/15 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, hypertension, diabetes type 2, dementia with behaviors, anxiety and depressive disorder.</p> <p>Review of the July 2015 Medication Administration Record(MAR) indicated the following:</p> <p>Resident B had a physician's order initially dated 9/29/14 for Bisacodyl EC Delayed Release 5 mg for constipation, to be given by mouth one time a day every 3 days at 8:00 a.m. The MAR lacked any documentation for the scheduled dose on 7/26/15.</p> <p>Resident B had an order initially dated 9/30/14 for Bystolic (anti hypertensive medication) 5 mg tablet, to be given my mouth one time a day at 8:00 a.m. The MAR lacked any documentation for the scheduled dose on 7/26/15.</p> <p>Resident B had an order dated 5/24/15</p>		<p>The licensed nurses responsible for administering resident B's medications stated she did administer the</p> <p>Bisacodyl EC 5mg, Bysoic 5mg, Colace 100mg, Gapepentin 300mg and Hydrochlorothiazide 25mg as ordered on 7/26/15 at 8:00 a.m. She states she inadvertently omitted her initials (documentation) on the medication administration record.</p> <p>The licensed nurse responsible for administering resident D's Novolog Insulin 12 units on 7/22/15 at 12:00 p.m. and 5:00 p.m. states that she did give the Novolog Insulin as ordered. The nurse states she inadvertently omitted her initials (documentation) on the medication administration record.</p> <p>The licensed nurse responsible for administering resident D's insulin on 7/27/15 states that she did give the resident Novolog Insulin 6 units as ordered based on sliding scale. The nurse states she omitted her initials (documentation) on medication administration record.</p> <p>The licensed nurse responsible for administering resident E's insulin on 7/25/15 and 7/26/15 state that Levemir Flex Pen Injector doses were given as ordered. The nurses state that the documentation was inadvertently omitted. The licensed nurses were counselled/educated</p>	

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	<p>for Colace Capsule 100 mg, to be given by mouth two times a day at 8:00 a.m. and 8:00 p.m. The MAR lacked any documentation for the scheduled dose on 7/26/15 at 8:00 a.m.</p> <p>Resident B had an order dated 9/30/14 for Gabapentin Capsule 300 mg, to be given by mouth one time a day at 8:00 a.m. for neuropathy The MAR lacked any documentation for the scheduled dose on 7/26/15.</p> <p>Resident B had an order dated 9/30/14 for Hydrochlorothiazide (anti hypertensive medication) 25 mg tablet, to be given by mouth one time a day at 8:00 a.m. The MAR lacked any documentation for the scheduled dose on 7/26/15.</p> <p>2. The clinical record for Resident D was reviewed on 7/27/15 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, dementia, diabetes type 2, depressive disorder, anxiety and hypertension.</p> <p>Review of the July 2015 Medication Administration Record(MAR) indicated the following:</p> <p>Resident D had an order dated 9/28/14 for Novolog Solution 12 units to be</p>		<p>one on one on facility policy titled Medication Administration-General Guidelines (see attachment A).</p> <p>The resident's did not have a negative outcome from omission of documentation.</p> <p>Beginning on 7/29/15, licensed nurses were educated on the policy titled Medication Administration-General Guidelines (See attachment A). All licensed nurses were re-educated on Medication Administration-General Guidelines at nurses in-service on 8-6-15 (see attachment B) and the new required process for ensuring this does not occur in the future.</p> <p>All licensed nurses will be responsible for reviewing their medication administration records for accuracy prior to the end of their shift and correct any inaccuracies.</p> <p>This process will be monitored by utilizing the Quality Assurance QA tool Medication Documentation review. (See attachment C). The DON or designee will audit 5x's weekly X 6 weeks, then weekly thereafter. Any non-compliance will be investigated immediately and appropriate documentation will be completed. This will in turn ensure that the records for each resident is complete and accurate. If there are omissions/inaccuracies in the medication documentation they will</p>	

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	<p>injected subcutaneously two times a day at 12:00 p.m. and 5:00 p.m., for diabetes type 2. The MAR lacked any documentation for the 12:00 p.m. and the 5:00 p.m. scheduled dose on 7/22/15.</p> <p>Resident D had an order dated 6/8/15 for Novolog Solution, for diabetes type 2, per sliding scale as follows: If blood sugar is 150-200 give 4 units, 201-250 give 6 units, 251-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units, 401- 450 give 14 units, 451 give 16 units and notify MD. The MAR lacked any documentation for the 7/22/15 scheduled dose at 11:00 a.m.</p> <p>3. The clinical record for Resident E was reviewed on 7/27/15 at 10:08 a.m. Diagnoses for the resident included, but were not limited to, cerebrovascular accident, diabetes type 2, chronic kidney disease and depressive disorder.</p> <p>Review of the July 2015 Medication Administration Record(MAR) indicated the following:</p> <p>Resident E had an order dated 9/17/14 for Levemir Flex Pen injector 100 units/milliliters to be injected subcutaneously at bedtime for diabetes type 2. The MAR lacked any documentation for the 8:00 p.m.</p>		<p>be considered "medication errors" in the future and disciplinary measure may ensue for repeated omissions.</p> <p>The results of the audits and process will be reviewed by the Quality Assurance Committee at least monthly. Any recommendations will be followed. The nurse was counselled/educated one on one on facility policy titled Medication Administration-General Guidelines (see attachment A). The care plan was followed.</p> <p>Systemic changes will be completed by 8/15/15.</p>	

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	<p>scheduled dose on 7/25/15 and 7/26/15.</p> <p>Resident D had an order dated 9/28/14 for Novolog Solution 12 units to be injected subcutaneously two times a day at 12:00 p.m. and 5:00 p.m., for diabetes type 2. The MAR lacked any documentation for the 12:00 p.m. and the 5:00 p.m. scheduled dose on 7/22/15.</p> <p>During an interview on 7/28/15 at 10:15 a.m., RN #1 indicated all medications given during a shift should be signed off at the time of administration. She indicated everyone should check the MAR before they end their shift to double check everything has been signed off appropriately.</p> <p>During an interview on 7/27/15 at 3:52 p.m., the Director of Nursing indicated she did not know why the documentation on the MARs was missing. She indicated she would follow up with nursing staff responsible for the missing documentation. No further information was provided.</p> <p>A current policy dated 6/15/2010 titled "Physician Order Transcription Procedure", was provided by the Administrator on 7/28/15 at 12:00 p.m. The policy indicated the following: "Policy: A. It is the policy of Miller's</p>			

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	<p>Merry manor to ensure that physician orders are transcribed and maintained in a manner that ensures safety upon administration.</p> <p>...H. Special circumstance orders- III. Documentation on the administration records: Initials are entered legibly after the medication or tx[treatment] is administered.</p> <p>Circling an initial indicates that the procedure or med as not administered. *If the procedure or medication is not given due to refusal, LOA, held etc. the initial is circles, then a corresponding code will be entered in the box with the initial explaining why it was not done."</p> <p>A current policy dated 10/4/2012 titled "Medication Administration Procedure" was provided by the Administrator on 7/28/15 at 12:00 p.m. The policy indicated the following: "Administering Oral Medications ...23. Document initials on the administration record and any other assessment/information needed. ..."</p> <p>This federal tag relates to Complaints IN00178119.</p> <p>3.1-50(a)(1)</p>			

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

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