

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN 46970
--	---

(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
--------------------	--	---------------	---	----------------------

F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 11, 12, 13 and 14, 2016</p> <p>Facility number: 000014 Provider number: 155039 AIM number: 100288670</p> <p>Census bed type: SNF/NF: 58 SNF: 04 Total: 62</p> <p>Census payor type: Medicare: 6 Medicaid: 39 Other: 17 Total: 62</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on April 15, 2016.</p>	F 0000	The facility requests a paper compliance review of this plan of correction.	
------------------------	---	--------	---	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/14/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN 46970		
(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	
F 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review, the facility failed to ensure an over bed light was accessible for Resident #70, to ensure a call light was within reach for Resident #4 and to ensure the call light preference for Resident #6 was met. This affected 3 of 40 residents reviewed for accommodation of needs.</p> <p>Findings include:</p> <p>1. On 4/11/2016 at 3:09 P.M., Resident #70's over bed light was observed to have an approximately 3 inch chain attached. The chain was used to turn the light on and off. The bed light was located approximately above the resident's head of her bed, 5 1/2 feet above the floor level. Resident #70 was unable to reach the chain to turn her light on and off.</p>	F 0246	<p>CORRECTIVE ACTION(S) FOR THOSE AFFECTED:</p> <p>1. For Resident #70, on 4/14/16, a longer cord was attached to the 3-inch chain, so that the resident could turn the over bed light on and off. This resident has since been discharged from the facility.</p> <p>2. For Resident #4, during the surveyor's observation at 10:26 AM on 4/14/16, Employee #2 placed the call light cord within reach of the resident.</p> <p>3. For Resident #6, on 4/14/16, the facility ordered a new breath call light device. The resident continued to use his touch pad call light device until his replacement breath call light device was installed on 4/19/16.</p> <p>CORRECTIVE ACTION(S) FOR OTHERS AFFECTED:</p> <p>On 4/19/16 maintenance staff inspected all resident rooms to ensure that over bed light cords were</p>	05/09/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/14/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN 46970		
(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	
	<p>During an interview on 4/14/2016 at 10:37 A.M., Resident #70 indicated she was unable to turn the light on in her room due to not being able to reach the chain.</p> <p>During an interview on 4/14/2016 at 10:38 A.M., Employee #3 indicated there should be a long string attached to the chain to make the light accessible to Resident #70.</p> <p>On 4/14/2016 at 3:00 P.M., the Administrator provided the policy titled "Resident Environment," dated 5/31/2016, and indicated this was the policy currently used by the facility. The policy indicated "...A. Policy 1. The resident environment includes the facility, the grounds and especially the resident room. When a resident enters a long-term care facility, he or she experiences the loss of home and belongings. The staffs goal is to help each resident make the room his or her own. Familiar things create a positive environment...."</p> <p>2. On 04/12/2016 at 2:42 P.M., Resident #4's call light was observed draped over the bedside stand at the foot of her bed, out of reach for the resident.</p>		<p>accessible to all residents.</p> <p>On 4/14/16 facility staff inspected all occupied resident rooms to ensure that call light cords were placed within reach of residents.</p> <p>No other residents currently require or have requested an adaptive call light device.</p> <p>MEASURES TO PREVENT RECURRENCE:</p> <p>All staff will be in-serviced on 5/6/16 regarding the necessity of placing over bed light cords and call light devices within reach of residents in their rooms. In-service will also include the directive that all employees are responsible to report to maintenance any call light device or over bed cord that needs to be repaired or serviced.</p> <p>Disciplinary action will be taken, per facility policy, with an employee who does not demonstrate commitment to keep over bed light cords or call light devices within reach of residents; or with an employee who does not report that a call light device or over bed light cord needs to be repaired or serviced.</p> <p>To monitor for compliance, maintenance staff will complete the "Review of Call Lights/Over Bed Lights" (Attachment A) weekly for four (4) weeks, then monthly thereafter for ten (10) residents, each time including those who need or prefer an adaptive call light device. Any identified issues will be corrected upon discovery and logged on the facility QA tracking log.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN 46970
--	---

(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
	<p>On 4/14/2016 at 10:24 A.M., Resident #4's call light was observed to be draped over the call light box on the wall, out of reach of the resident.</p> <p>During an interview on 4/14/2016 at 10:26 A.M., Employee #2 indicated Resident #4's call light was not within reach and she placed the call light within reach of the resident.</p> <p>3. On 4/12/2016 at 2:07 P.M., Resident #6's mouth piece call light was observed to be out of reach.</p> <p>On 4/14/2016 at 10:00 A.M., Resident #6's mouth piece call light was observed to be out of reach of the resident. It was observed to be connected to the residents bed, however the mouth piece was facing the opposite direction of the resident.</p> <p>During an interview on 4/12/2016 at 2:07 P.M., Resident #6 indicated he had an accessible call light he could touch on his abdomen, however he preferred his mouth piece call light which he could manipulate easier due to his limitations. He indicated he was unable to use his mouth piece call light because it had not been functioning for the last three weeks.</p> <p>During an interview on 4/14/2016 at 10:40 A.M., Employee #3 indicated he</p>		<p>MONITORING TO PREVENT RECURRENCE:</p> <p>The maintenance director will submit the QA tracking logs to the monthly meeting of the QA committee, which will review the logs and make any further recommendations to ensure that call light devices and over bed cords are placed within reach of residents.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN 46970
--	---

(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
F 0309 SS=D Bldg. 00	<p>was unaware Resident #6's mouth piece call light was not functioning and he ordered a new one.</p> <p>On 4/14/2016 at 3:00 P.M., the Administrator provided the policy titled "Resident Environment," dated 5/31/2006, and indicated this was the policy currently used by the facility. The policy indicated "...B. Resident Room 1. The residents room contains all of the things necessary to make the resident feel safe and comfortable and usually includes the: h. Call System: Used by the resident to request assistance - must be on the residents unaffected side and within reach whenever the resident is alone in their room or the bathroom...."</p> <p>3.1-3(v)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and</p>	F 0309	It is the policy of the facility to	05/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/14/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN 46970		
(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	
	<p>interview, the facility failed to ensure insulin was given to 1 of 3 residents according to physician order. (Resident #14)</p> <p>Findings include:</p> <p>During a medication pass observation, conducted on 04/14/16 at 8:30 A.M., Resident #14 was administered 10 units of Humalog insulin for the sliding scale coverage for a blood sugar level of 223 and 4 units of Humalog insulin for his routine coverage by RN #11.</p> <p>During a medication pass observation, conducted on 04/14/16 at 11:14 A.M., Resident #14 was administered 14 units of Humalog insulin for the sliding scale coverage for blood sugar level of 271 and 4 units of Humalog insulin for his routine coverage by RN #11. The resident was not given any food or drink with his insulin administration, except for water. The resident was not taken to the dining room and given a glass of milk and lemonade until 11:55 A.M.</p> <p>On 04/14/16 at 2:45 P.M. the medication orders for Resident #14 were reviewed. The physician's order for the routine and sliding scale Humalog insulin, dated 03/15/16, indicated the following: "Start Humalog ij [sic] pen solution inject 4</p>		<p>ensure that physician orders and manufacturer's instructions for the administration of fast acting insulin are followed correctly.</p> <p>CORRECTIVE ACTION(S) FOR THOSE AFFECTED: Resident #14's Medication Administration Record (MAR) was reviewed to ensure that it accurately reflects the physician's order for the time to give the Humalog. Once the resident's blood sugar is checked, the Humalog will be given 15 minutes or less prior to the resident receiving a snack or meal. Documentation of the snack or meal offered will be completed on the MAR.</p> <p>CORRECTIVE ACTION(S) FOR OTHERS AFFECTED: The MARs of all other diabetic residents will be audited by nursing managers to ensure that the orders accurately reflect the physician's order for the time to give insulin. Once the blood sugars are checked, the insulin will be given according to the manufacturer's instructions. Documentation of the snack or meal offered will be completed on the MAR.</p> <p>MEASURES TO PREVENT RECURRENCE: By 5/6/16 all nurses will be in-serviced on manufacturer's instructions for the giving of fast acting insulin, including the guidelines for the appropriate time frame for the resident receiving a</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/14/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN 46970		
(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	
	<p>units subcutaneously [sic] at 0700 [7:00 A.M.], 1100 [11:00 A.M.], 1700 [5:00 P.M.] on 03/17/16. Start Humalog inj (injection) pen solution inject per sliding scale of ...201 - 250 = 10 units...subq [subcutaneous] 4 x [times] a day for DM [Diabetes Mellitus]. Give 15 min [minutes] before meals or snack."</p> <p>During an interview on 04/14/16 at 1:45 P.M., RN #11 indicated she had administered Resident #14's insulin just after his breakfast as she thought short acting insulin could be administered just before or right after a resident ate their meal. She indicated she was in the dining room, off of the unit, 15 minutes before Resident #14 had been served his breakfast.</p> <p>During an interview on 04/14/2016 at 1:52 P.M., the Director of Nursing (DON) indicated the insulin administration times were originally included in the orders to ensure residents did not receive their insulin too early and she thought the times on the insulin orders were being clarified and removed.</p> <p>During an interview on 4/14/16 at 2:30 P.M., the Assistant Director of Nursing (ADON) indicated the facility did not have a specific policy regarding the administration of short acting insulin but</p>		<p>snack or meal after the insulin is given. The in-service will also include instruction that the nurse will document on the MAR that the snack or meal was offered within the appropriate time frame.</p> <p>Disciplinary action will be taken, per facility policy, when a nurse commits a medication error related to the administration of insulin or a nurse does not document that manufacturer's instruction was followed for offering a snack or meal.</p> <p>The Director of Nursing (DON) or designee will complete the Quality Assurance (QA) tool "Blood Glucose Monitoring Review" (Attachment B) weekly for four (4) weeks for ten (10) residents and then monthly thereafter for ten (10) residents to monitor for compliance. Any identified issues will be corrected upon discovery and logged on the facility QA tracking log.</p> <p>MONITORING TO PREVENT RECURRENCE:</p> <p>The DON or designee will submit the QA tracking logs to the monthly meeting of the QA committee, which will review the logs and make any further recommendations to ensure that physician orders and manufacturer's instructions for administration of fast acting insulin are followed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN 46970
--	---

(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
	"followed the manufacturer's instructions." A copy of an insert from "epocrates.com/drugs" for Humalog insulin, provided by the ADON on 04/14/16 at 2:30 P.M. indicated the Humalog insulin was to be administered "less than 15 minutes or immediately after meals...." 3.1-37(a)			