

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 07/16/2015
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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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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00177473.</p> <p>Complaint IN00177473 - Substantiated. Federal/State deficiencies related to allegations are cited at F157, F282 and F431.</p> <p>Survey date: July 16, 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: 10 Medicaid: 31 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 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified when there was a medication error for 1 of 4 residents reviewed for physician notification. (Resident C)</p>	F 0157	F157 Resident C's physician was notified of the omitted dose of stated medication. An order was obtained to administer the medication on 7/2/15. This was carried out as ordered. Resident	08/15/2015			

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	<p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 7/16/15 at 2:30 p.m. Diagnoses for Resident C included, but were not limited to, Alzheimer's disease, anxiety, cardiomegaly, chronic airway obstruction and hypertension.</p> <p>Review of the Medication Administration Record (MAR), dated July 2015, indicated a new order for miconazole (topical anti-fungal) 200 mg vaginal suppository was received. The medication was ordered on 6/30/15 and the initial dose was given on 7/1/15. The medication was to be administered for three days. On 7/2/15, a note on the MAR indicated the dose was "not given".</p> <p>Review of a current care plan, dated 6/29/15, indicated Resident C had a problem related to excoriation to the vaginal area. Interventions included, but were not limited to, "apply treatment as ordered, notify MD [medical doctor] if area becomes worse and monitor the area every shift until healed."</p> <p>On 7/16/15 at 2:45 p.m., RN #1 indicated she did not administer the suppository because "it was one of those crazy nights." She indicated she was unsure if</p>		<p>C did not have a negative outcome. All residents have the potential to be affected by this deficiency. All current residents' medication administration sheets were audited for omission of medication doses. There were not any identified that required physician notification. RN #1 was counseled, one on one and re-educated on Medication Error procedure. On 7-22-15, all licensed nurses were re-educated on facility Medication Error policy, including MD notification and medical record documentation. (See attachment A&B). This will be monitored per Q.A. tool, titled <u>Medication Error Review</u>. (See attachment C) weekly for 6 weeks, bi-weekly for 6 weeks, then monthly for 6 months. Any non-compliance will be corrected immediately. The results of the audits will be reviewed by the Quality Assurance Committee and any recommendations will be followed. The person responsible will for monitoring will be DON, or her designee. Systematic changes will be completed by 8-15-2015.</p>	

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	<p>the physician was notified of the missing dose.</p> <p>On 7/16/15 at 4:30 p.m., the Administrator indicated no documentation was found indicating the physician was notified Resident C did not receive the 7/2/15 dose of miconazole.</p> <p>Review of a current facility policy, dated 9/17/13, titled "Medication & Treatment Error Procedure", which was provided by the Administrator on 7/16/15 at 4:14 p.m., indicated the following:</p> <p>"...1. FORMS: *Medication and Treatment Error Report</p> <p>2. PURPOSE: *To safeguard the resident</p> <p>...3. PROCEDURE: A. Medication errors and drug reactions must be reported immediately to the attending physician and responsible party. B An entry of the incident must be made in the resident's clinical record, and medication error report. ...G. Nurse/QMA directly involved in the error will be re-educated and/or counseled and the documentation of such will be placed on page 2 of the Medication and Treatment error form and</p>						

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F 0282 SS=D Bldg. 00	<p>placed in the employee's file."</p> <p>This Federal tag relates to Complaint IN00177473.</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 a Care Plan was followed as written for 1 of 4 residents reviewed for care planning. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 7/16/15 at 2:30 p.m. Diagnoses for Resident C included, but were not limited to, Alzheimer's disease, anxiety, cardiomegaly, chronic airway obstruction and hypertension.</p> <p>Review of the Medication Administration Record (MAR), dated July 2015, indicated a new order for miconazole (topical anti-fungal) 200 mg vaginal suppository was received. The medication was ordered on 6/30/15 and</p>	F 0282	<p>F282</p> <p>The Medication Error form was completed by the facility, on 7-17-15 for Resident C and the physician was updated with details. The care plan was reviewed for Resident C.</p> <p>All residents have the potential to be affected by this deficiency. All current residents' medication administration sheets were audited for omission of medication doses. There were not any identified that required physician notification. RN #1 was counseled, one on one and re-educated on Medication Error procedure.</p> <p>All Licensed Nurses, including RN#1, were given one on one education on Medication Administration Policy and the Medication error procedure beginning 7-30-15. Each signed their</p>	08/15/2015

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F 0431 SS=D Bldg. 00	<p>the initial dose was given on 7/1/15. The medication was to be administered for three days. On 7/2/15, a note on the MAR indicated the dose was "not given".</p> <p>Review of a current care plan, dated 6/29/15, indicated Resident C had a problem related to excoriation to the vaginal area. Interventions included, but were not limited to, "apply treatment as ordered, notify MD [medical doctor] if area becomes worse and monitor the area every shift until healed."</p> <p>On 7/16/15 at 2:45 p.m., RN #1 indicated she did not administer the suppository because "it was one of those crazy nights."</p> <p>This Federal tag relates to Complaint IN00177473.</p> <p>3.1-35(g)(1)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and</p>		<p>understanding of the policy. All licensed nursing staff will be re-in serviced on a routine basis and as needed.</p> <p>This will be audited with Q.A. audit tool, <u>Care Plan Review</u> (See attachment D). This will monitored weekly for 6 weeks, bi-weekly for 6 weeks, then monthly for 6 months. Any non-compliance will be corrected immediately. The results of the audits will be reviewed by the Quality Assurance Committee and any recommendations will be followed.</p> <p>DON or designee will conduct audits.</p> <p>Systematic changes will be completed by 8-15-15</p>		

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	<p>periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were stored in a secure manner to prevent potential access at all times by unauthorized users for 1 of 2 halls observed. (Hall 100, Resident B, RN #2)</p> <p>Findings include:</p> <p>During the initial tour on 7/16/15 at 9:00 a.m., Room 107 was observed to have a medicine cup containing orange liquid.</p>	F 0431	<p>F431</p> <p>RN #2 administered the lactulose and observed the resident swallow it per medication policy as soon as it was brought to her attention. RN #2 was re-educated on securing medications and observing residents swallow them.</p> <p>All residents have the potential to be affected by this practice. There were not any other medications found unattended during rounds of the</p>	08/15/2015

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	<p>The resident residing in the room was asleep in her recliner and the medication was left on the night table.</p> <p>During an interview on 7/16/15 at 9:05 a.m., RN #2 indicated the medication in the cup was lactulose (liquid laxative). She indicated she thought the resident was just getting ready to drink it. She indicated it was not normal practice to leave medication at the bedside. RN #2 was seated at the nurses' station during the observation.</p> <p>On 7/16/15 at 9:45 a.m., Resident B indicated "I have been in the facility long enough they [staff] know I will take my pills."</p> <p>The clinical record for Resident B was reviewed on 7/16/15 at 9:55 a.m. Diagnoses for Resident B included, but were not limited to, bipolar, depressive disorder, anxiety, chronic airway obstruction and hypertension.</p> <p>Review of the Medication Administration Record (MAR), dated July 2015, lactulose 10 gram/5 mL was ordered on 11/16/14. The medication was to be given daily at 8:00 a.m.</p> <p>Review of a current care plan, dated 5/31/13 and revised on 6/7/13, indicated</p>		<p>entire facility.</p> <p>All Licensed Nurses, including RN#2, were given one on one education on Medication Administration Policy (attachment E) and the Medication Error Procedure (Attachment A) beginning 7-30-15. Each signed their understanding of the policy. All licensed nursing staff will be re-in-serviced on a routine basis and as needed.</p> <p>This will be audited through the Q.A. process using QA tool <u>Medication Pass Observation. (see attachment E)</u> weekly for 6 weeks, bi-weekly for 6 weeks, then monthly for 6 months. Any non-compliance will be corrected immediately. The results of the audits will be reviewed by the Quality Assurance Committee and any recommendations will be followed.</p> <p>DON or designee will conduct audits.</p> <p>Systematic changes will be completed by 8-15-15</p>	

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	<p>Resident B had a problem related to constipation. Interventions included, but were not limited to, "administer laxatives and/or stool softeners as ordered and encourage fluid intake."</p> <p>During an interview on 7/16/15 at 4:30 a.m., the Administrator indicated Resident B did not have a self-administration assessment and was not to administer her own medications.</p> <p>Review of a current facility policy, dated 10/4/12, titled "Medication Administration Procedure", which was provided by the Administrator on 7/16/15 at 1:10 p.m., indicated the following:</p> <p>"Goal: The patient will swallow the medication.</p> <p>...2. Move the med cart to outside of the resident room or prepare in the med room.</p> <p>...4. Unlock the med cart.</p> <p>...13. Lock the medication cart before leaving it.</p> <p>14. Transport the medications to the resident and keep in sight at all times.</p> <p>...21. Remain with the resident until each</p>			

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	<p>medication is swallowed. Never leave medication with the resident."</p> <p>This Federal tag relates to Complaint IN00177473.</p> <p>3.1-25(m)</p>				