

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 5909 LUTE RD PORTAGE, IN 46368
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F000000	<p>This visit was for the Investigation of Complaint IN00147603</p> <p>Complaint IN00147603 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F333.</p> <p>Survey dates: April 23, 2014</p> <p>Facility number: 000196 Provider number: 155299 AIM number: 100267390</p> <p>Survey team: Heather Hite, RN-TC Caitlyn Doyle, RN Julie Ferguson, RN Jennifer Redlin, RN</p> <p>Census bed type: SNF: 2 SNF/NF: 57 Total: 59</p> <p>Census payor type: Medicare: 11 Medicaid: 26 Other: 22 Total: 59</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 28, 2014, by Janelyn Kulik, RN.</p>	F000000	Please accept the attached plan of correction as our credible allegation of compliance. The facility respectfully requests paper compliance.	
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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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F000282 SS=D	<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 were followed related to insulin administration for 1 of 5 diabetic residents reviewed for insulin administration. (Resident #D)</p> <p>Findings included:</p> <p>Resident #D's closed record was reviewed on 4/23/14 at 9:50 a.m. The resident's diagnoses included, but were not limited to, diabetes, chronic kidney disease, dementia, depressive disorder, and anxiety.</p> <p>Review of Physician's Orders upon admission 4/7/14 included, but was not limited to, the following diabetic orders:</p> <ul style="list-style-type: none"> - Insulin Aspart (Novolog) (Short-acting insulin): Inject 7 units subq (subcutaneous, under the skin) 4x daily for diabetes - Levemir SC (Long-acting Insulin): Inject 20 units subq every night at 9pm for diabetes - Glucagon 1 mg (milligram) injection intramuscular: inject as needed if BS , 70 and resident is non-responsive, recheck BS after 15 minutes and notify MD <p>Order change dated 4/8/14 indicated:</p> <ul style="list-style-type: none"> - Glucagon 1 mg PRN for blood sugar < 50 and unable to swallow - Make Novolog PRN sugar > 350. Notify for sugar < 50 or > 400. 	F000282	<p>It is the policy of Miller's Merry Manor, Portage that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care. Resident D was discharged from the facility. All residents receiving insulin and or blood sugars are at risk to be affected by the deficient practice. The nurse management team completed an audit of all diabetic charts and physician orders related to diabetes by 4/16/14. All licensed nursing staff were in-serviced on or before 4/23/14 regarding facility policies for insulin administration, types of insulin (fast acting, long acting), guidelines for when different insulins should be administered, importance of following physician orders, and preventing significant medication errors. Charge nurses were observed by a nurse manager for all insulin administration from 4/11/14 thru 4/18/14 to monitor for timely/correct insulin administration. Nurse managers participate in random walking rounds on various shifts to observe that physician orders for insulin administration are</p>	05/07/2014			

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	<p>Review of the Medication Administration Record (MAR) for April 2014 indicated the following handwritten order to begin 4:00 p.m. on 4/8/14: "Blood sugar check 4x daily at 7a, 11a, 4p, 9p. Give Novolog 7 units if BS is > 250, give coverage 15 minutes prior to meal/snack." The same order was indicated on the computer generated MAR dated beginning 4/9/14.</p> <p>Review of Resident #D's BS log from the April 2014 MAR, included, but were not limited to the following results: 4/9/14 4:30 p.m. - BS 323 - Novolog given 4/9/14 9:30 p.m. - BS 420 - Levemir given, Novolog given 4/10/14 7 a.m. - BS 213 4/10/14 11:30 a.m. - BS 349 - Novolog given 4/10/14 4:30 p.m. - BS 436 - Novolog given late</p> <p>During a phone interview with Resident #D's daughter on 4/23/14 at 1:30 p.m., she indicated she arrived to visit the resident around 7:00 p.m. on 4/10/14. The nurse on duty (LPN #1) came in the room "a little while later" and reminded the resident she had checked her blood sugar before dinner & was going to give her insulin now. The daughter further indicated LPN #1 told her Resident #D had eaten her supper "at her usual time" and gave Resident #D's Insulin - Novolog 7 units at 7:42 p.m.</p> <p>In an interview with the Director of Nursing (DoN) on 4/23/14 at 1:50 p.m., she indicated there was no time charted for the insulin administration to Resident #D on the evening of 4/10/14, but had spoken with LPN #1 later that evening and confirmed it had been given "around 7:45 p.m." The DoN indicated this was late and should have been given right</p>		<p>being followed. All newly hired charge nurses participate in an 11day orientation which specifically reviews facility policies for care of diabetics, insulin administration, and glucometer use to ensure physician orders are followed. The QA tool titled " Diabetic Review" will be completed by the DON or other designee daily for 1 week, then three times per week for 4 weeks, then biweekly for 4 weeks, then weekly thereafter to monitor for ongoing compliance. The in-service director completes quarterly medication observation of each nurse a minimum of quarterly which includes insulin administration observation to monitor for ongoing compliance. Any identified issues will be corrected upon discovery with immediate staff retraining and logged on facility QA tracking log. The QA tracking logs are reviewed monthly during the facility QA meeting to monitor for compliance.</p>				

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F000333 SS=D	<p>before dinner.</p> <p>This Federal Tag Relates to Complaint Number IN00147603.</p> <p>3.1-35(g)(2) 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interview, the facility failed to ensure residents were free from a significant medication error related to insulin administration for 1 of 5 residents reviewed for insulin administration. (Resident #D)</p> <p>Findings included:</p> <p>Resident #D's closed record was reviewed on 4/23/14 at 9:50 a.m. The resident's diagnoses included, but were not limited to, diabetes, chronic kidney disease, dementia, depressive disorder, and anxiety.</p> <p>Review of Physician's Orders upon admission 4/7/14 included, but was not limited to, the following diabetic orders: - Insulin Aspart (Novolog) (Short-acting insulin): Inject 7 units subq (subcutaneous, under the skin) 4x daily for diabetes - Levemir SC (Long-acting Insulin): Inject 20 units subq every night at 9pm for diabetes - Glucagon 1 mg (milligram) injection intramuscular: inject as needed if BS < 70 and resident is non-responsive, recheck BS after 15 minutes and notify MD. Order change dated 4/8/14 indicated:</p>	F000333	Miller's Merry Manor, Portage has policies and procedures in place for preventing significant medication errors. Resident D was discharged from the facility. All residents receiving insulin and or blood sugars are at risk to be affected by the deficient practice. The nurse management team completed an audit of all diabetic charts and physician orders related to diabetes by 4/16/14. All licensed nursing staff were in-serviced on or before 4/23/14 regarding facility policies for insulin administration, types of insulin (fast acting, long acting), guidelines for when different insulins should be administered, importance of following physician orders, and preventing significant medication errors. Charge nurses were observed by a nurse manager for all insulin administration from 4/11/14 thru 4/18/14 to monitor for timely/correct insulin administration. Nurse managers participate in random walking rounds on various shifts to observe that physician orders for	05/07/2014			

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	<p>- Glucagon 1 mg PRN for blood sugar < 50 and unable to swallow - Make Novolog PRN sugar > 350. Notify for sugar < 50 or > 400.</p> <p>Review of the Medication Administration Record (MAR) for April 2014 indicated the following handwritten order to begin 4:00 p.m. on 4/8/14: "Blood sugar check 4x daily at 7a, 11a, 4p, 9p. Give Novolog 7 units if BS is > 250, give coverage 15 minutes prior to meal/ snack." The same order was indicated on the computer generated MAR dated beginning 4/9/14.</p> <p>Review of Resident #D's BS log from the April 2014 MAR, supplemented by Progress Notes indicated the following results: 4/7/14 4 p.m. - BS 286 - Novolog given 4/7/14 9 p.m. - BS 109 - Levemir given, Novolog held 4/8/14 6 a.m. - BS 116 - Novolog given 4/8/14 8:30 a.m. - BS 23 - Glucagon given, MD on site 4/8/14 8:45 a.m. - BS 35 4/8/14 9:15 a.m. - BS 93 4/8/14 11 a.m. - BS 235 - Novolog given 4/8/14 4 p.m. - BS 323 - Novolog given 4/8/14 9 p.m. - BS 343 - Levemir given, Novolog given 4/9/14 7 a.m. - BS 248 4/9/14 11:15 a.m. - BS 236 4/9/14 4:30 p.m. - BS 323 - Novolog given 4/9/14 9:30 p.m. - BS 420 - Levemir given, Novolog given, MD notified 4/10/14 7 a.m. - BS 213 4/10/14 11:30 a.m. - BS 349 - Novolog given 4/10/14 4:30 p.m. - BS 436 - Novolog given late, MD notified</p> <p>A policy titled "Administering a Subcutaneous Injection" was provided by the DoN on</p>		<p>insulin administration are being followed. All newly hired charge nurses participate in an 11day orientation which specifically reviews facility policies for care of diabetics, insulin administration, and glucometer use to ensure physician orders are followed. The QA tool titled " Diabetic Review" will be completed by the DON or other designee daily for 1 week, then three times per week for 4 weeks, then biweekly for 4 weeks, then weekly thereafter to monitor for ongoing compliance. The in-service director completes quarterly medication observation of each nurse a minimum of quarterly which includes insulin administration observation to monitor for ongoing compliance. Any identified issues will be corrected upon discovery with immediate staff retraining and logged on facility QA tracking log. The QA tracking logs are reviewed monthly during the facility QA meeting to monitor for compliance.</p>				

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	<p>4/23/14 at 9:35 a.m. an deemed as current. The policy indicated "... 13. Ensure that the resident receives the med at the correct time - 60 min before or after scheduled time"</p> <p>A professional resource, titled, "Nursing 2014 Drug Handbook", page 748 indicated under guidelines for Novolog administration: "Insulin is a safety alert drug (drug that presents a heightened avoidable danger)" and "Give 5 to 10 minutes before start of meal by subcutaneous injection."</p> <p>During a phone interview with Resident #D's daughter on 4/23/14 at 1:30 p.m., she indicated she arrived to visit the resident around 7:00 p.m. on 4/10/14. The nurse on duty (LPN #1) came in the room "a little while later" and reminded the resident she had checked her blood sugar before dinner & was going to give her insulin now. The daughter further indicated LPN #1 told her Resident #D had eaten her supper "at her usual time" and gave Resident #D's Insulin - Novolog 7 units at 7:42 p.m.</p> <p>In an interview with the Director of Nursing (DoN) on 4/23/14 at 1:50 p.m., she indicated there was no time charted for the insulin administration to Resident #D on the evening of 4/10/14, but had spoken with LPN #1 later that evening and confirmed it had been given "around 7:45 p.m." The DoN indicated this was late and should have been given right before dinner. She further indicated the facility had deemed this a medication error, completed an investigation, and had conducted inservices with staff.</p> <p>In a further interview at 3:30 p.m., the DoN indicated she did not know when the resident had eaten dinner on 4/10/14, but usually ate</p>				

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	<p>in her room and room trays were delivered between 5:00 - 5:30 p.m.</p> <p>In an interview with the DoN and Nurse Consultant regarding medication policies on 4/23/14, the Nurse Consultant indicated there was "no policy specific to the timing of insulin administration. General medication timing is for 60 minutes before or after scheduled time unless giving a time-sensitive medication, which would include insulin. Nursing judgement should be to give within 15 minutes before eating."</p> <p>This Federal Tag Relates to Complaint Number IN00147603.</p> <p>3.1-48(c)(2) 3.1-25(b)(9)</p>			