

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/04/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: December 1, 2, 3 and 4, 2014.</p> <p>Facility number: 000578 Provider number: 155627 AIM number: 100267810</p> <p>Survey team: Angela Selleck, RN TC Jason Mench, RN Shelley Reed, RN Toni Maley, BSW (December 1, 2, & 3, 2014)</p> <p>Census bed type: SNF/NF: 26 Total: 26</p> <p>Census payor type: Medicare: 3 Medicaid: 21 Other: 2 Total: 26</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora</p>	F000000	<p>To Whom It May Concern,</p> <p>Please accept the enclosed plan of correction as credible allegation of compliance for each deficiency cited during the annual Indiana State Department of Health Survey conducted on December 4, 2014. We respectfully request consideration for paper compliance for our submitted plan of correction. We respectfully request to informally dispute the F463 citation via paper review. Should you have any questions or need additional information, please do not hesitate to contact me at 260-563-4112.</p> <p>Sincerely,</p> <p>Amanda Harris Administrator</p>	
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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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F000431 SS=D	<p>Barth, RN.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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 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</p>						

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	<p>dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure bottles of medications, vials of medications and packets of medications were properly labeled and disposed of following expiration dates for 2 of 2 medication carts observed. (North hall and West hall medication carts).</p> <p>Findings include:</p> <p>1. During an observation of medication storage with the MDS (Minimum data set) Coordinator on 12/2/14 at 9:06 a.m., the medication cart on the North hall contained an unsealed package of budesonide inhalation suspension (an inhaled corticosteroid medication used to prevent asthma symptoms) 0.5 milligrams/2 milliliters with an open date of 11/20/14. The package was located in the fourth drawer of the medication cart and had two vials of medication remaining in the package with no resident's name or the dosage to be administered.</p> <p>During an interview with the MDS Coordinator on 12/2/14 at 9:06 a.m., she indicated it must be Resident #9's medication due to it was in her section of the medication cart. She further indicated there was no resident's name or</p>	F000431	<p>F-Tag 431 Drug Records, Label/Store Drugs and Biologicals:</p> <p>It is the policy of Miller's Merry Manor, Wabash West to ensure that 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>All issues noted have been resolved. There were no negative outcomes to any resident.</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>All nurses to be re-educated on 12-22-14 on the policy and procedure for Storage of Medications.</p> <p>The DON/Designee will complete the QA Audit Tool "Medication Room/Refrigeration Storage Review" (Attachment A) and "Medication Cart Audit" (Attachment B) weekly x 4 weeks,</p>	01/03/2015

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	<p>room number to distinguish the different sections.</p> <p>2. During an observation of a medication pass on the North hall with LPN #2 on 12/2/14 at 3:32 p.m., a small white plastic basket located in the second drawer of the North hall medication cart was observed to contain 30 packets of potassium bicarbonate tablet effervescent (a medication used for hypokalemia) 25 milliequivalents (978 milligrams). The packets were not labeled with a resident's name or the dosage to be administered.</p> <p>During an interview with LPN #2 on 12/2/14 at 3:32 p.m., she indicated the medication was for Resident #2. She indicated she had just thrown the box away which held the packets. LPN #2 indicated they had always stored the medication packets that way. She indicated the packets are stored in the resident's section of the medication cart. LPN #2 further indicated there was no resident's name or room number to distinguish the different sections.</p> <p>During an interview and observation of the North medication cart with the Nurse Consultant and LPN #2 on 12/2/14 at 3:35 p.m., the Nurse Consultant indicated the medications were to have a label which was to include the resident's name</p>		<p>then every 2 weeks for 4 weeks, then monthly thereafter. Any concerns will be addressed immediately and then logged on the "Quality Improvement Summary Log" (Attachment C). The corrective actions will be monitored through the monthly QA meeting to ensure ongoing compliance.</p> <p>Date of compliance: 1-3-15</p>				

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	<p>and the dosage to be administered. The Nurse Consultant indicated the medications could not be placed in the medication carts without the resident's name and the dosage to be administered.</p> <p>During an interview with the Nurse Consultant and the Director of Nursing (DON) on 12/4/14 at 1:21 p.m., the DON indicated medications should be labeled with the physician instructions and the resident's name.</p> <p>The Nurse Consultant indicated the medications needed to have labels on them because if the medications were not labeled, how would someone know a medication was for a specific resident, especially if the medication drawers were to get messed up.</p> <p>3. During an observation of medication storage with the MDS Coordinator on 12/2/14 at 9:31 a.m., the eighth drawer of the medication cart on the West hall contained a bottle of guaifenesin syrup (a liquid medication used to prevent cough) 100 milligrams/5 milliliters with a dispense date of 10/2/13 and an unreadable dispense amount on the label for Resident #11. The MDS coordinator indicated the medication had 120 milliliters remaining in the bottle with an expiration date of 10/14.</p>			

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	<p>The DON indicated the medication carts were checked monthly for expired medications. The DON indicated the expired medication was missed and slipped through the monthly audit of the medication carts.</p> <p>During a phone interview with the Pharmacy Consultant on 12/4/14 at 1:40 p.m., she indicated she was at the facility to audit the medication carts on 10/13/14 and 11/10/14. She indicated her focus was to observe for expired medications used "as needed" (PRN).</p> <p>4. A review of a current facility policy titled "STORAGE OF MEDICATIONS", dated 6/1/11, which was provided by the Nurse Consultant on 12/2/14 at 4:30 p.m. indicated the following:</p> <p>"STORAGE OF MEDICATIONS</p> <p>Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier...</p> <p>...a. The pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices. Medications are kept in these containers.</p>						

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F000463 SS=D	<p>Transfer of medications from one container to another is done only by the pharmacy.</p> <p>...j. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal...and reordered from the pharmacy...if a current order exists.</p> <p>...l. Medication storage conditions are monitored on a regular basis and corrective action taken if problems are identified."</p> <p>3.1-25(o)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure a resident's call light was functional for 1 of 23 residents reviewed for functional call lights. (Resident #6)</p>	F000463	<p>F463 Resident Call System-Rooms/Toilet/Bath: It is the policy of Miller's Merry Manor West that there will be a communication system in place in which the nurses station will be equipped to receive resident calls</p>	01/03/2015			

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	<p>Findings include:</p> <p>During an observation of Resident #6's room (room #3-2) on 12/1/14 at 9:00 a.m., the call light would not sound after multiple separate attempts. The call light for Resident #6's roommate and the bathroom light sounded when activated.</p> <p>During an observation of Resident #6's room (#3-2) on 12/2/14 at 9:00 a.m., the call light would not sound after multiple separate attempts. The call light for Resident #6's roommate and the bathroom light sounded when activated.</p> <p>During an observation of Resident #6's room (#3-2) on 12/3/14 at 2:16 p.m., the call light would not sound after multiple separate attempts. CNA #1, the DON and the Administrator were brought to Resident #6's room and each pushed the call light and it did not sound. The roommate's call light sounded when pressed.</p> <p>During an Interview with the Administrator on 12/3/14 at 2:16 p.m., she indicated the previous call light in that room had stopped working on 12/1/14 and was replaced the morning of 12/1/14 and was working at the time of replacement.</p> <p>During an interview with the</p>		<p>from resident rooms; and toilet and bathing facilities. Resident #6: The call light for this resident was immediately repaired when the surveyor brought this to the attention of the facility. All other resident call lights were checked and there were no other issues noted. Resident did not have any negative affects related to this issue. All residents in the facility have the potential to be affected by this deficient practice. All other call lights in the facility were tested and no other issues were noted. To ensure this does not reoccur the Maintenance director/designee will complete audits two times weekly for 2 weeks on all call lights in the facility utilizing the QA Tool "Call Light Audit" (Attachment D). Then the audits will be completed weekly for four weeks and then monthly thereafter ongoing. All issues noted during auditing will be addressed immediately and noted on the QA Problem Summary Log (Attachment C). The log will be reviewed and followed through the monthly facility Quality Assurance Meeting. Date of Compliance: 1-3-15 IDR F463 Resident Call</p> <p>System-Rooms/Toilet/Bath: Facility staff through established QA process, noted call bell in question was not functioning on Monday, December 1st prior to the surveyors' entry into the facility. A maintenance slip was</p>				

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F000502 SS=D	<p>Maintenance Supervisor on 12/4/14 at 11:40 a.m., he indicated he checked the call lights monthly and also prior to a resident moving into the facility with the last check being completed on 11/20/14. He indicated he followed the following steps outlined in the maintenance guidelines:</p> <p>"1. For each department, notify the appropriate person in charge that the call system is being tested.</p> <p>2. Check wall station in each patient room. Repair as necessary.</p> <p>3. Check call cords in bathrooms and shower rooms. Ensure call cord length is no more than 6" from the floor. Repair as necessary..."</p> <p>3.1-19(u)(1)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview, the facility failed to ensure labs were completed for 1 of 5 residents reviewed</p>	F000502	<p>completed and the malfunctioning call bell was replaced. The new call bell was tested and noted to be functioning properly. This was verified by the Administrator and Director of Nursing. (Attachment G) Resident number #6 rarely uses the call bell and is dependent on staff for all care. At a minimum, resident is checked and/or cared for every two hours. Facility staff were unaware call bell was malfunctioning again until Wednesday December 3rd after a surveyor notified the Director of Nursing it was not working. Surveyor communicated that the call bell was noted to not be working on the afternoon of Monday, December 1st and again on Tuesday, December 2nd yet did not alert facility staff until two days after they first observed this. Facility feels if this concern warrants a citation, the survey team had an obligation to report this so it could be repaired at the point of discovery rather than two days later. Miller's Merry Manor respectfully requests this citation to be deleted from the record.</p> <p>F502 Administration: It is the policy of Miller's Merry Manor, Wabash West that laboratory</p>	01/03/2015	

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	<p>for lab results. (Resident #4)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #4 was reviewed on 12/2/14 at 1:36 p.m. Diagnoses for the resident included, but were not limited to, chronic kidney disease, iron deficient anemia and depression.</p> <p>A Physician's order, dated 5/30/14, Indicated a BMP (Basic Metabolic Panel) and a CBC (Complete Blood Count) were ordered "every 3 months (DUE: MARCH, JUNE, SEPT, DEC)." Both of these labs were used to monitor chronic kidney disease and iron deficient anemia.</p> <p>A review of the health care plan last reviewed on 9/9/14 indicated the following: Problems: "chronic kidney disease and iron deficient anemia..." The interventions included, but were not limited to the following: "monitor labs as ordered...."</p> <p>The review of the June 2014 "Medication Record" indicated with initials of "HR", the CBC and BMP labs were completed on 6/18/14.</p> <p>A review of the labs completed June 2014 for Resident #4 indicated no lab</p>		<p>services will be provided to meet the needs of the residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Resident #4 suffered no adverse effects as a result of this cited deficiency.</p> <p>All residents have the potential to be affected by this deficient practice. All current resident lab orders will be reviewed to ensure proper labs have been completed and results are present on the clinical record.</p> <p>All nurses will be re-educated on the proper procedure and necessary forms to complete when receiving a lab order from the physician on 12-22-14. The DON/designee will be tracking all labs. To ensure the deficient practice does not recur. The QA Tool "Lab Review" (Attachment E) will be utilized. This tool will be completed on 25% of the resident population monthly x 4 months, and then the tool will be completed on 10% of the resident population quarterly thereafter indefinitely. Any issues identified will be addressed immediately and logged on the "Quality Improvement Summary Log" (Attachment C). The corrective action will be reviewed and followed through QA at the monthly meeting.</p>		

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F000514	<p>results for a BMP and CBC.</p> <p>The review of the May and June 2014 "LAB & X-RAY TRACKING TOOL" indicated lab tests BMP and CBC for Resident #4 were not added to the form to be completed.</p> <p>During an interview with the Director of Nursing (DON) on 12/3/14 at 12:24 p.m., he indicated the labs CBC and BMP for Resident #4 were not completed. The DON further indicated they just became aware that these labs were not drawn, but signed off on the "Medication Record" that they had been drawn.</p> <p>The DON further indicated they do not have a Policy regarding lab draws, they use their "Quality Assessment/Improvement Program: Laboratory Review" worksheet, provided by the DON on 12/4/14 at 10:30 a.m., which indicated the following: "... if a lab draw is missed, the medication/treatment error form is completed and the physician is notified for direction...."</p> <p>3.1-49(a)</p> <p>483.75(l)(1)</p>		Date of Compliance: 1-3-15				

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SS=D	<p>RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>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 documentation was complete for physician notification related to elevated blood glucose levels for 1 of 5 residents reviewed for unnecessary medication use. (Resident #11)</p> <p>Findings include:</p> <p>The clinical record for Resident #11 was reviewed on 12/2/14 at 1:28 p.m. Diagnoses for Resident #11 included, but were not limited to, diabetes mellitus, hemiplegia, anemia, depressive disorder, peripheral vascular disease and congestive heart failure.</p> <p>The current physician's order indicated the following parameters for blood glucose monitoring; " BS [blood sugar]:</p>	F000514	<p>F514 Res Records-Complete/Accurate/Accessible: It is the policy of Miller's Merry Manor, Wabash West that the facility will 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>Resident #11 has had no negative outcomes related to the cited deficiency.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>All nurses re-educated on the importance and guidelines for</p>	01/03/2015
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	<p>Notify for BS less than 50 or greater than 400 as needed." The order was dated 7/8/14.</p> <p>Review of the September Medication Administration Record (MAR), indicated on 9/27/14, Resident #11's blood glucose level was 488 mg/dL. No signature was noted on the MAR for the blood glucose parameters out of range for 9/27/14.</p> <p>Review of a current Health Care Plan, dated 4/2/12 and revised 12/2/14, indicated Resident #11 had a problem related to hypo/hyperglycemia. Interventions for the problem included, but were not limited to, notify MD of blood sugar readings outside the ordered parameters, monitor blood sugars as ordered and give insulin/med as ordered.</p> <p>During an interview on 12/3/14 at 12:04 p.m., the Director of Nursing (DON) indicated he had spoken to the nurse who obtained the elevated blood sugar on 9/27/14 and she indicated by initialing in the box of the blood sugar level, unit dose and site location, it also meant she had contacted the physician. The DON indicated he would provide education to the nurse related to where to document physician notification for blood glucose levels outside the parameters.</p>		<p>documentation related to resident's physician orders for notification and the plan of care on 12-22-14.</p> <p>To ensure that this deficient practice does not reoccur the DON/Designee will monitor the nursing documentation utilizing the QA Tool "24 HR Report" (Attachment F). This will be completed daily for four weeks, then weekly for four weeks and then monthly thereafter. Any issues identified will be addressed immediately and added to the "QA Problem Summary Log" (Attachment C). These logs will be reviewed and addressed in the facility's monthly Quality Assurance meeting.</p> <p>Date of compliance: 1-3-15</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/04/2014	
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	<p>Review of a current facility policy date 7/1/01, which was provided by the DON on 12/4/14 at 11:00 a.m., indicated the following:</p> <p>" 1. POLICY</p> <p>*It is the policy of Miller's Merry Manor of to [sic] monitor blood glucose per physician's orders and to assess for signs of hypoglycemia or hyperglycemia.</p> <p>...4. PROCEDURE</p> <p>A. Privacy will be provided...</p> <p>B. Blood glucose readings shall be obtained...</p> <p>...IV. Document findings on the appropriate Blood Glucose Monitoring form. Document notification and ongoing assessment in progress notes."</p> <p>3.1-50(a)(1)</p>						