

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155574	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WALKERTON TR WALKERTON, IN 46574
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 12, 13, 14, 15, and 16, 2012</p> <p>Facility number: 000431 Provider number: 155574 AIM number: 100290380</p> <p>Survey team: Bobbie Costigan, RN TC Vicki Manuwal, RN</p> <p>Census bed type: SNF: 8 SNF/NF: 62 Total: 70</p> <p>Census payor type: Medicare: 8 Medicaid: 55 Other: 7 Total: 70</p> <p>Sample: 15</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 3/25/12</p>	F0000		

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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	Cathy Emswiller RN			

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to assess 1 of 2 resident's blood pressure and pulse to determine the need for a medication as ordered by the physician and failed to hold a medication when 1 of 2 resident's blood pressure was below the physician ordered hold level. This deficient practice affected 2 of 15 residents reviewed for medications to be given only when needed, in a sample of 15.</p> <p>Resident # 37, # 68</p>	F0329	It is the policy of Miller's Merry Manor of Walkerton that each resident's drug regimen must be free from unnecessary drugs. Resident # 37 and # 68 suffered no ill effects from this deficient practice. All residents have the potential to be affected by this same deficient practice. An in-service was given on 4/4/12 titled "Medication Administration: Standards of Practice" for RN's, LPN's and QMA's. The make-up date for those not in attendance will be given on an individual basis on that employee's next	04/13/2012			

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	<p>Findings include:</p> <p>1. The clinical record for Resident # 37 was reviewed on 3/15/12 at 10:50 A.M. The resident's diagnoses included, but were not limited to: hypertension, atrial fibrillation, and coronary artery disease.</p> <p>A "Physician Order" dated 12/9/10, indicated, "...Metoprolol ER (extended release) 25 mg 1 tab by mouth daily for CAD (coronary artery disease) at 9:30 A.M. Hold if SBP < [less than] 110 or pulse < 60..."</p> <p>Review of the December 2011, MAR (Medication Administration Record), January 2012, MAR, February 2012 MAR, and March 1st through 13 th, 2012, MAR lacked documentation of blood pressure readings to evaluate the necessity of the Metoprolol ER.</p> <p>Review of Resident # 37's care plan dated 12/14/10, indicated, "...Dx HTN (hypertension)...Monitor blood pressure per order..."</p> <p>During interview with the DON on 3/16/12 at 12:30 P.M., she indicated Resident # 37's MAR had been rewritten to include a space to document the blood pressure readings.</p>		<p>scheduled shift. The inservice included and reviewed the "Medication Administration Procedure" (Attachment A), the "Medication Error Procedure" (Attachment B), the "Medication Refusal Policy and Procedure" (Attachment C), the "Six Rights of Medication Administration" (Attachment D), and information on beta blockers and those beta blockers which should not be crushed (Attachment E). Skills assessment "Medication Pass Procedure" (Attachment F) will be done for all RN's, LPN's and QMA's per DON or designee by April 13. Then, 10 % of the nurse population will do the skills assessment monthly for three consecutive months, then after three months do 10% quarterly for 12 months, then progress to annually. Quality Assessment/Improvement Programs titled "Medication Error Review" (Attachment G) will be completed with a random sample of resident population up to 10% monthly times 3 months, then quarterly for 12 months, then per QA Program schedule. Inservice Director, Assistant Director of Nursing or Designee will be responsible for completion of this QA tool. Any identified issues will be logged on the "Quality Assurance Summary Log" (Attachment H). The log will be reviewed by the quality assurance committee on a monthly</p>		

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	<p>Review of a facility policy titled "Medication Administration Procedure" dated 3/23/11, indicated, "...Complete necessary assessments before administering medications..."</p> <p>2. The clinical record for Resident # 68 was reviewed on 3/13/12 at 9:35 A.M. The resident's diagnoses included, but were not limited to, hypertension, coronary artery disease, and dementia.</p> <p>A "Physician Order" originally dated 12/17/10, and updated 2/28/12 indicated, "...Metoprolol 50 mg (milligrams)...1 tab by mouth 2 x (times) daily at 8:30 A.M. and 4:30 P.M. for HTN (hypertension). Hold for SBP (systolic blood pressure) < (less than) 120 O (sic) HR (heart rate) < 60..."</p> <p>Review of the December 2011, MAR (Medication Administration Record), indicated Resident # 68's 8:30 A.M. BP (blood pressure) was 116/61. The MAR further indicated he received his Metoprolol when it should have been held.</p> <p>Review of the January 2012, MAR, indicated Resident # 68 received his scheduled Metoprolol on the following three occasions when his BP fell below</p>		<p>basis. Any concerns will be immediately corrected when found, the policy reviewed for changes and updated as applicable with committee approval at the QA meeting. Addendum F329:On March 26 th and April 6 th the pharmacy consultant was at the facility and reviewed all the meds for all residents and compared and validated the meds to the Medication Administration Record to insure their accuracy. All medications were also compared and validated to the physicians order. If something was incorrect the physician was notified and a new order was written and the correct medication delivered. To prevent this occurrence from happening again, the Medication Administration Record will be reviewed monthly along with a weekly recap when medications are delivered per the seven day cycle. The medications will be checked for strength, name, dose, time, etc. and compared to Medication Administration Record and physician order for accuracy as they are dispensed. Pharmacy Consultant will be here monthly to review medications on an ongoing basis.</p>				

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	<p>parameters:</p> <p>1/15/12 4:30 P.M. BP 118/60 1/16/12 4:30 P.M. BP 110/58 1/23/12 4:30 P.M. BP 118/58</p> <p>Review of Resident # 68's care plan dated 10/9/11, indicated, "...resident is at risk for compromised perfusion related to d/x (diagnosis) of hypertension (sic)...give hypertension (sic) med (medication) as ordered..."</p> <p>During interview on 3/15/12 at 5:00 P.M., the DON indicated there is no documentation in the chart as to why the medications were given or not given when indicated.</p> <p>3.1-48(a)(3)</p>				

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F0332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 % for 3 of 11 residents observed during two medication passes. Four errors in medication administration were observed during 45 opportunities for error. This resulted in a medication error rate of 8.9%.</p> <p>Resident # 5, # 28, # 38</p> <p>Findings include:</p> <p>1. Resident # 38</p> <p>The clinical record of resident # 38 was reviewed on 3/13/12 at 4:00 P.M.</p> <p>A "Physician Order", dated 8/4/11, indicated, "...Natural Tears 1 drop per eye 2 x (times) daily at 9:30 A.M., 4:30 P.M. for dry eyes..."</p> <p>During medication pass on 3/13/12 at 3:50 P.M., LPN # 2 instilled one drop of Natural Tear into each eye of Resident # 38 then after one minute, instilled another drop into each eye.</p>	F0332	<p>It is the policy of Miller's Merry Manor, Walkerton that each resident's medications are administered as ordered by a physician and medication error rates are less than 5%.Residents #5, #28, #38 suffered no ill effects from medications not being administered as ordered by the physician and having a med error rate of 5% or more.All residents have the potential to be affected by the same deficient practice.Inservice titled "Medication Administration: Standards of Practice" was given on 4/4/12 for all RN's, LPN's, and QMA's. Make up date for those not in attendance will be given on an individual basis on that employee's next scheduled shift. The inservice included and reviewed the "Eye Drops and Eye Ointment Procedure" (Attachment I), "Medication Administration Procedure" (Attachment A), "Metered Dose Inhaler Administration" (Attachment J), "MDI Spacer" (Attachment K), "Oral Dosage Forms That Should Not Be Crushed (Attachment L), "Medication Error Procedure" (Attachment B). Skills assessment "Medication Pass Procedure" (Attachment F) will be done for all RN's, LPN's</p>	04/13/2012			

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	<p>During interview with LPN # 2 on 3/13/12 at 4:10 P.M., she indicated she gave the resident two drops into each eye instead of one.</p> <p>2. Resident # 5</p> <p>The clinical record of resident # 5 was reviewed on 3/13/12 at 4:50 P.M.</p> <p>A "Physician Order", originally dated 7/1/10, and updated on the physician recap orders of March 2012 indicated, "...Carb/Levo 25/100 mg (milligrams) 2 tab by mouth 5 x daily at 7 A.M., 11 A.M., 3 P.M., 7 P.M., & 11 P.M. for Parkinson's..."</p> <p>During medication pass on 3/13/12 at 4:35 P.M., LPN # 3 gave Resident # 5 two Carbidopa-levodopa pills.</p> <p>During interview with LPN # 3 on 3/13/12 at 4:55 P.M., she indicated you can give a resident scheduled medications one hour prior or one hour after the scheduled time to still be within the proper timeframe. She further indicated she did not give the medication in the allotted time.</p> <p>The Nursing Spectrum Drug Handbook, 2010 edition, indicated, "...Carbidopa-Levodopa...give dose as</p>		<p>and QMA's per DON or designee by April 13. Then, 10% of the nurse population will do the skills assessment monthly for three consecutive months, then after three months do 10% quarterly for 12 months, then progress to annually. Quality Assessment/Improvement Programs titled "Medication Error Review" (Attachment G) will be completed with a random sample of resident population up to 10% monthly times three months, then quarterly for 12 months, then per QA Program schedule. Inservice Director, Assistant Director of Nursing or Designee will be responsible for completion fo this QA tool. Any identified issues will be logged on the "Quality Assurance Summary Log" (Attachment H). The log will be reviewed by the quality assurance committee on a monthly basis. Any concerns will be immediately corrected when found, the policy reviewed for changes and updated as applicable with committee approval at the QA meeting. "Plan of Correction Inservice Regarding Med Error Deficiencies" Post Exam (Attachment M) was given to all RN's, LPN's and QMA's at the conclusion of the inservice. F332Addendum F332:On March 26 th and April 6 th the pharmacy consultant was at the facility and reviewed all the meds for all residents and compared and validated the meds to the</p>		

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	<p>close as possible to time ordered to ensure stable drug blood level..."</p> <p>3. Resident # 28</p> <p>The clinical record of resident # 28 was reviewed on 3/14/12 at 9:00 A.M.</p> <p>A "Physician Order", originally dated 10/8/10, and on the physicians recap orders dated March 2012 indicated, "...Symbicort 160/4.5 2 puffs inhalation: inhale with adaptor 2 x daily at 8:30 A.M. and 4:30 P.M. for COPD (chronic obstructive pulmonary disease)..."</p> <p>Another "Physician Order", originally dated 12/6/10, and on the physicians recap orders dated March 2012 indicated, "...Metoprol Tartrate XL (extended length) 50 mg 1 tab by mouth 1 x daily at 8:30 A.M. for HTN (hypertension)..."</p> <p>During medication pass on 3/14/12 at 8:55 A.M., LPN # 4 crushed Resident # 28's metoprolol succinate ER (extended release) 50 mg. She then administered Resident # 28 her Symbicort inhaler without the use of an adapter.</p> <p>During interview with LPN # 4 on 3/14/12 at 8:56 A.M., LPN # 4 indicated it would be documented on the MAR if a medication could be crushed or not. She</p>		<p>Medication Administration Record to insure their accuracy. All medications were also compared and validated to the physicians order. If something was incorrect the physician was notified and a new order was written and the correct medication delivered. To prevent this occurrence from happening again, the Medication Administration Record will be reviewed monthly along with a weekly recap when medications are delivered per the seven day cycle. The medications will be checked for strength, name, dose, time, etc. and compared to Medication Administration Record and physician order for accuracy as they are dispensed. Pharmacy Consultant will be here monthly to review medications on an ongoing basis.</p>				

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	<p>further indicated medications such as extended release or enteric coated couldn't be crushed.</p> <p>During interview with LPN # 4 on 3/14/12 at 9:05 A.M., she indicated pharmacy had previously given an authorization for the facility to crush the metoprolol succinate ER.</p> <p>During interview with the DON on 3/14/12 at 9:55 A.M., she indicated she thought it was care planned for all meds to be crushed. She further indicated she thought the physician had previously given an authorization to crush her medications.</p> <p>The clinical record lacked documentation of any physician notification or authorization to crush the metoprolol succinate ER. The resident's record lacked a care plan for crushing of any medications.</p> <p>During interview with LPN # 5 on 3/16/12 at 3:55 P.M., she indicated there was not an adaptor available in the medication cart for Resident # 28's inhaler.</p> <p>The Nursing Spectrum Drug Handbook, 2010 edition, indicated, "...metoprolol succinate...tablet...should be swallowed</p>			

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	<p>whole and not crushed..."</p> <p>Review of a facility policy titled "Medication Administration Procedure" dated 3/23/11, indicated, "...Compare the label with the administration record....Altering of medication: Ensure that there is a physician's order stating it is acceptable to crush tablets...Ensure that the resident receives the med at the correct time-60 min before or after scheduled time...."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			