

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155583	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1367 S RANDOLPH ST GARRETT, IN 46738
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 26, 27, 28, 29, & 30, 2012</p> <p>Facility number: 000499 Provider number: 155583 AIM number: 100266120</p> <p>Survey team: Rick Blain, RN - TC Sue Brooker, RD Diane Nilson, RN Angela Strass, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 52 Total: 61</p> <p>Census payor type: Medicare: 3 Medicaid: 44 Other: 14 Total: 61</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	The facility respectfully requests to IDR F-Tag 441 and F-Tag 520. Please accept the attached POC as our credible allegation of 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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F0241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review the facility failed to ensure dignity during dining for 5 residents (Residents #7, #15, #23, #37, and #30) of 45 residents who ate their meals in the main dining room.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal in the main dining room on 11/26/12 at 11:43 a.m., the following was observed:</p> <ul style="list-style-type: none"> - Resident #7 was observed seated in his wheelchair at a table in the main dining room. His wheelchair was very low to the height of the table. He was observed reaching his arms upward above the height of the dining table to reach his food. The height of the dining room table was at the same level as his upper forearm. - Resident #15 was observed seated in her wheelchair at a table in the main dining room. Her wheelchair 	F0241	<p>It is the policy of Miller's Merry Manor, Garrett to promote care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Residents #: 7, 15, 23, 37, and 30 were all individually reassessed, interviewed, and then offered accommodations for other seating arrangements, adaptive equipment, or alternate table height. All residents elected to remain in the same location/seating assignment and their preferences were added to each individual plan of care. The facility will continue to provide dining room seating accommodations to residents in an effort to enhance/maintain resident dignity in dining. All residents are at risk to be affected by the deficient practice. The dietary manager or other designee will assess all residents for dignity in dining by 12/30/12. Any issues will be reviewed and plan of care updated to reflect preferences and/or accommodations to ensure dignity. An all staff in-service will be held on 12/21/12</p>	12/30/2012			

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	<p>was very low to the height of the table. She was observed reaching her arms upward above the height of the dining table to reach her food. The height of the dining room table was at the same level as her upper forearm.</p> <p>- Resident #23 was observed seated in her wheelchair at a table in the main dining room. Her wheelchair was very low to the height of the table. She was observed reaching her arms upward above the height of the dining table to reach her food. The height of the dining room table was at the same level as her upper forearm.</p> <p>- Resident #37 was observed seated in her wheelchair at a table in the main dining room. Her wheelchair was very low to the height of the table. She was observed reaching her arms upward above the height of the dining table to reach her food. The height of the dining room table was at the same level as her upper forearm.</p> <p>- Resident #30 was observed seated in her wheelchair at a table in the main dining room. Her wheelchair was extremely low to the height of the table. She was observed holding her</p>		<p>to review the procedure for ensuring resident dignity in dining. The facility assesses each resident at admission, quarterly, and with significant change in status to determine/identify preferences for daily routine, likes/dislikes, need for dining accommodations, and specific care routines. The facility promotes dignity in dining by allowing each resident the opportunity to choose their seating location. Staff will be instructed to communicate to charge nurse any resident concerns regarding need for dining accommodations or any staff observations of need to make accommodations to enhance resident dignity will be communicated to the charge nurse for further evaluation. The dietary manager and/or nurse manager will participate in routine walking rounds during random meals to monitor for proper chair to table height/positioning and to observe for continued compliance. The dietary manager or other designee will be responsible to complete the quality assurance tool titled " Dignity in Dining" (Attachment 1) weekly x4 weeks, then monthly thereafter. Any identified trends will be corrected upon discovery and then logged on facility quality assurance log to be reviewed at the monthly quality assurance meeting to ensure ongoing compliance.</p>		

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	<p>hamburger in her hands just above her lap. She yelled out several times during the meal she could not see her food. The height of the dining room table was at the same level as her eyes.</p> <p>Resident #7 was interviewed on 11/17/12 at 10:00 a.m. During the interview he indicated it bothered him he sits so low in his wheelchair at the dining room table, but it was because he is so short. He also indicated sitting so low at the table in his wheelchair made it difficult for him to eat, especially to stir his hot chocolate.</p> <p>Resident #15 and Resident #23 were interviewed on 11/17/12 at 11:23 a.m. During the interview they indicated they sat at the same table in the main dining room. They both indicated it would be nice to sit at a lower table so they would not have to raise their arms up so high above the height of the table to get something to eat. Resident #23 further indicated she had discussed the height of her dining table with the facility, but nothing had been done.</p> <p>Resident #37 was interviewed on 11/17/12 at 11:28 a.m. During the</p>				

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	<p>interview she indicated having a lower dining room table would make it easier at mealtime.</p> <p>2. During an observation of the lunch meal in the main dining room on 11/27/12 at 11:41 a.m., the following was observed:</p> <p>Resident #15 was observed seated in her wheelchair at the same table in the main dining room as observed on 11/26/12. Her elbows were observed approximately 2 inches below the top of the table. Her forearms were bent up toward the ceiling from her elbows with her lower forearm almost touching her upper forearm while taking food from her plate and eating. Resident #15's chin was approximately 2 inches above her lunch plate.</p> <p>- Resident #23 was observed seated in her wheelchair at the same table in the main dining room as observed on 11/26/12. When eating her lunch she was observed to keep her forearms bent up from her elbow toward the ceiling in order to reach her food on her plate. Her chin was approximately 2 inches above her lunch plate and her elbows were approximately 3 inches below the top of the table.</p>						

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	<p>Resident #7 was observed seated in his wheelchair at the same table in the main dining room as observed on 11/26/12. He was observed to sit back in his wheelchair and use his left hand on the arm rest of his wheelchair to push himself up and to move closer to the table. His elbows were below the top of the table and he kept his right forearm bent up from his elbow toward the ceiling while eating.</p> <p>- Resident #37 was observed seated in her wheelchair at the same table in the main dining room as observed on 11/26/12. Her chin was approximately 2 inches above her lunch plate. Her elbows were approximately 3 inches below the top of the table and her forearms were bent up from her elbows toward the ceiling while eating.</p> <p>- Resident #30 was observed seated in her wheelchair at the same table in the main dining room as observed on 11/26/12. Her wheelchair was extremely low so the height of the dining room table was level with her eyes. She yelled out during the meal she needed to be closer to the table. Staff were observed to adjust the foot rests on her wheelchair and pushed</p>						

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	<p>her wheelchair as close to the table as they could. The height of the dining room table remained at the same level of her eyes. She was observed to hold her hamburger in her hands just above her lap to eat.</p> <p>The facility Administrator was interviewed on 11/17/12 at 11:40 a.m. During the interview she indicated the residents choose where they want to sit in the dining room and getting them to move to a different table was next to impossible. The Administrator was again interviewed on 11/29/12 at 2:43 p.m. During the interview she indicated the facility currently had one adjustable dining room table. She also indicated the facility had tried to place those residents who required a shorter table at the adjustable table, but they declined.</p> <p>The Certified Dietary Manager was interviewed on 11/30/12 at 9:25 a.m. During the interview she indicated the facility only had one table which adjusted in height to accommodate residents who were short in stature. She also indicated the facility had installed a lower shelf to one dining table which accommodated one resident who could not sit close enough to the dining room due to her</p>				

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	<p>wheelchair.</p> <p>A facility "Resident Rights Handbook", dated 12/2011 and provided by the Administrator on 11/29/12 at 3:00 p.m., indicated "...The resident has a right to a dignified existence...The resident has the right to be treated with consideration, respect and recognition of their dignity and individuality...."</p> <p>3.1-3(t)</p>			

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F0431 SS=E	<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 dose can be readily detected.</p> <p>Based on observation, record review, and interview the facility failed to ensure medications were properly labeled for 2 residents (Resident #64</p>	F0431	It is the policy of Miller's Merry Manor, Garrett to assure medications are labeled in accordance with currently accepted professional standards.	12/30/2012			

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	<p>and Resident #70) on 2 of 3 medication carts observed for labeling of medications and failed to ensure expired medications were removed from 1 of 1 medication refrigerators (Resident #19).</p> <p>Findings include:</p> <p>Observation of the medication room was made with the Director of Nursing Services on 11/27/12, at 11:52 a.m. An unopened bottle of Omeprazole suspension (a medication to treat heartburn) for Resident #19, dated 10/30/12, with an expiration date of 11/12/12, was observed in the refrigerator in the medication room. The DNS indicated the resident at one time was receiving this suspension through a feeding tube, but was no longer getting the medication via this route.</p> <p>The DNS, was interviewed, at 3:26 p.m., on 11/27/12, and indicated 2 bottles of the Omeprazole were delivered on 10/30/12 and one bottle was partially used when the resident was still getting her medication through the feeding tube, but the other bottle was not used, and the resident had been changed to oral tablets. She indicated the medication should have been destroyed. She</p>		<p>Resident # 19: The expired bottles of omeprazole were destroyed on 11/27/12. All of residents medications were checked to ensure compliance with expiration date. Resident# 64, and # 70 OTC meds were labeled with resident name and physician. All OTC medication bottles shall have the original manufacturer's label and the facility will write the resident name and physician on the bottle upon receipt. The facility policy for "Medication Labels" has been updated to include specific criteria for OTC medications. All residents are at risk to be affected by the deficient practice of expired medications. Two residents were at risk to be affected by the deficient practice. The two residents utilize an outside pharmacy that does not put a pharmacy label on OTC medications. All other residents utilize the facility pharmacy and all pharmaceuticals/ OTC medications come with a pharmacy label attached. All licensed nursing staff will be in-serviced on 12/ 21 /12 the policy/procedure for labeling of OTC medications. Nurses instructed that the bottle must be unopened upon receipt and that an order for use must be present in the EMR. The bottle must have the manufacturer's label and the nurse will write the resident name and physician name legibly on the bottle. In-service</p>				

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	<p>indicated the day shift unit manager was supposed to check the medications in the refrigerator, but since the medication expired on 11/12/12, she had not checked the refrigerator as this was only done monthly.</p> <p>The medication cart on the back hall, was checked at 2:20 p.m., on 11/29/12, with LPN # 2. Medications or supplements for Resident #70 were in a drawer in the medication cart, but the bottles of medication did not have the physician's name on them. The medications or supplements were as follows: Equate complete multivitamin 2 bottles of Fish Oil 1000 milligrams 2 bottles of cranberry 500 mg capsules.</p> <p>There was an open bottle of Super flex joint formula, a dietary supplement, with no resident or physician's name on the bottle. LPN #2 indicated the Super flex belonged to Resident #64.</p> <p>The medication cart on the Front hall, was checked with the Quality Assurance Nurse Consultant, at 2:50 p.m., on 11/29/12. An opened bottle of Gaviscon</p>		<p>education also reviewed expiration dates and the process for disposing expired medications. Expired medications will not be stored in the facility med room refrigerator or med cart beyond the expiration date. Facility charge nurses will be responsible to assist in continued compliance thru routine observation of cart during medication pass. The consultant pharmacist visits monthly and routinely audits facility medication carts and medication room for compliance. Any issues found during consultant pharmacist quality review is communicated to the DON or other designee at the time of consultants exit conference. The facility unit manager or other designee will be responsible to complete the "Medication Cart/Med Room Audit Review " (Attachment 2) weekly on all med carts for 4 weeks, then bi-monthly on each cart on an ongoing basis to ensure continued compliance. Any identified issues will be corrected immediately and logged on facility QA tracking log. The QA tracking logs and immediate actions taken will be discussed during the monthly Quality Assurance Meeting.</p>		

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	<p>extra-strength was observed in the medication drawer, with no resident or physician name on the bottle. A bottle of Antacid 1000 mg tablets, which was about 1/2 full, had no resident or physician name on the bottle.</p> <p>The Quality Assurance Nurse Consultant indicated she didn't know who the medications belonged to, and indicated they would be destroyed.</p> <p>The Quality Assurance Nurse Consultant was interviewed, at 10:05 a.m., on 11/30/12, and indicated there was no facility policy for over the counter labeling of medications, but she would expect that the resident's and physician's name would be on the label, as per their facility policy for prescription medications.</p> <p>3.1-25(o) 3.1-25(j)</p>				

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F0441	The facility requests to IDR F-Tag 441 with the scope and	12/30/2012			

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	<p>ensure glucometers were disinfected prior to use for 2 of 3 residents observed for blood glucose checks (Resident #55 and Resident #8). The facility also failed to ensure nursing staff washed hands during medication passes for 4 of 16 residents observed (Residents' #55, #12, #49, and #7).</p> <p>Findings include:</p> <p>1. During a medication administration pass observed on 11/28/12 at 4:45 P.M., RN #4 was observed to remove a glucometer from the medication cart and enter the room of Resident #8. RN #4 was observed to obtain a sample of blood from the resident with the glucometer test strip. The nurse was observed to clean and disinfect the glucometer after testing Resident #8's blood sample, but was not observed to clean and disinfect the glucometer prior to obtaining a blood sample from Resident #8. During an interview at that time, RN #4 indicated she had not disinfected the glucometer prior to testing Resident #8's blood glucose. RN #8 further indicated she assumed the glucometer had been cleaned and disinfected by the nurse on the previous shift according to facility policy, but she did not know if the previous nurse had actually cleaned</p>		<p>severity of an E and requests that the tag be considered for deletion or the scope and severity at a minimum be reduced. F-Tag 441 Infection Control: It is the policy of Miller's Merry Manor, Garrett to to maintain an infection control program that is designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. Resident # 8 and Resident # 55: RN #4 and LPN # 1 followed the proper procedure for cleaning and disinfecting of the glucometer after obtaining a resident blood sugar. Resident #55, # 12, #49, #7: LPN #1 has received 1:1 re-education on facility protocol for hand-washing and participated in medication pass observation to ensure knowledge and compliance. All residents are at risk to be affected by the deficient practice. An all nursing staff in-service will be held on 12/21/12 to review the facility policy/procedure for glucometer cleaning/disinfecting. Charge nurses will be responsible to communicate to oncoming shift nurse that the glucometer was properly cleaned after each use per facility policy. All nursing staff who participate in medication administration will attend an in-service on 12/21/12 to review the policy and procedures for hand-washing during medication</p>		

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	and disinfected the glucometer.		administration. The DON or other designee will complete a med pass observation of all nurses who participate in medication administration by 12/30/12 to ensure compliance. The in-service will specifically review situations when hand-washing and gloving are required to ensure infection control standards. Nurse managers will be responsible to make random walking rounds on all shifts during medication administration times to monitor for continued compliance. All newly hired charge nurses participate in an 11 day orientation program that includes orientation to the facility infection control practices. Each charge nurse performs a return demonstration of glucometer cleaning/disinfecting, hand-washing, and medication administration pass before performing skills independently. The In-service Director or other designee will be responsible to complete quarterly competencies with all charge nurses for "Hand-washing" and "Med Pass Observation" to ensure ongoing compliance. The nurse managers will be responsible to perform random observations of 3 med passes per month with documentation of any findings and reviewed during monthly QA meeting. The DON or other designee will be responsible to complete the "Blood Glucose Review" (Attachment 3) on 10%	

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	<p>2. During the medication pass, at 3:25 p.m., on 11/28/12, LPN #1 was noted to take a glucometer out of a drawer on the medication cart on the front hall. She did not disinfect the glucometer, was not observed to wash or use a sanitizer to cleanse her hands, and donned a pair of gloves. The LPN went into Resident #55's room, performed a blood sugar reading using the glucometer, then removed her gloves, walked to the medication cart, disinfecting the glucometer, but was not observed to wash or cleanse her hands. The LPN then was noted to prepare an oral medication for Resident #49, gave the medication to the resident, then used a hand sanitizer to cleanse her hands.</p> <p>At 3:40 p.m., on 11/28/12, LPN #1 prepared an oral medication for Resident # 48, gave the resident the medication, then proceeded to push Resident #12 in her wheelchair from the hall into her room, did not wash or cleanse her hands, retrieved the glucometer from the medication cart,</p>		<p>of facility census per month. Any findings will be logged on facility quality assurance tracking log along with immediate actions taken. The tracking logs will be reviewed during the monthly facility quality assurance meeting to ensure ongoing compliance.</p>				

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	<p>donned gloves, and proceeded to perform a blood sugar test on the resident. The LPN then removed the gloves, disinfected the glucometer per facility protocol, but did not cleanse or wash her hands.</p> <p>LPN #1 then pushed the medication cart back to the nurse's station without washing or cleansing her hands. At 4:08 p.m., the LPN drew up insulin into a syringe, donned gloves, and gave the insulin injection to Resident #55, who was in her room. The LPN disposed of the used syringe on her medication cart, and without cleansing or washing her hands, proceeded to go into Resident #7's room. The LPN donned another pair of gloves which were in the resident's room, and proceeded to assist the resident who had a bloody nose. Another staff member brought the LPN a washcloth, which the LPN wet then used to place on the resident's nose to help stop the bleeding. She then removed the gloves and washed her hands in the sink in the room.</p> <p>The LPN then went to the medication cart, drew up insulin in a syringe for Resident #12, donned gloves, and proceeded to give the resident the insulin injection. She then removed the gloves, and without cleansing or washing her hands, left the resident's</p>						

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	<p>room and went to the dining room, put on an apron, and began to assist residents in the dining room with their menu orders.</p> <p>LPN #1 was interviewed, at 4:40 p.m., on 11/28/12, regarding disinfection of the glucometers prior to use. She indicated the nurses were supposed to disinfect the glucometers immediately after using, so she had not disinfected the glucometer prior to testing Resident # 55's blood sugar, because she thought it had already been disinfected by the previous nurse.</p> <p>The Director of Nursing Services, and the Quality Assurance Nurse Consultant, were interviewed, at 11:05 a.m., on 11/29/12 regarding disinfecting procedures for the glucometers and the hand washing policy. The DNS indicated the glucometers were disinfected after each use, so she would not expect any nurse to use the glucometer and place it back in the medication cart contaminated. She indicated she would expect the nurses to follow facility policy and disinfect after use. She indicated the facility policy was not to clean right before use, but after use of the glucometer.</p>				

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	<p>The DNS also indicated she would expect staff to wash their hands after removing gloves.</p> <p>Review of the Policy "Cleaning of Glucometer", provided by the DNS, at 11:30 a.m., on 11/29/12, indicated, "After completing a blood sugar on one resident and before doing a blood sugar on another resident, use a commercial disinfectant wipe (Clorox, Lysol, Gulf South etc) and completely wipe down the glucometer so it is visibly wet. " The policy further indicated to follow the manufacturer's instructions related to length of time to disinfect before re-using, place the Glucometer in a covered container and set the timer for manufacturer's contact kill time, and once contact kill time had expired, to wait and allow to air dry before re-using.</p> <p>On 11/30/12, at 8:45 a.m., the facility policy for use of medical gloves, application and removal, dated 6/9/2010, was provided by the DNS. Review of the policy, at 9:00 a.m., on 11/30/12, indicated the following: Gloves should not be used as a substitute for hand-washing; Hands should be washed initially prior to putting on the gloves; Gloves should be removed and hands washed with soap and water</p>				

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	<p>immediately after glove removal. Hand washing with soap and water was highly recommended when gloves were removed because of a tear or puncture and the health care worker had contact with blood or another body fluid, hand rub with alcohol gel may be used only if soap and water was not available upon removal of gloves.</p> <p>Gloves should be removed and hands washed between care activities with residents.</p> <p>3.1-18(a) 3.1-18(l)</p>				

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F0520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to ensure the facility's Quality Assessment and Improvement (QAI) Committee identified concerns regarding the labeling of medications, potentially affecting all residents in the facility who are administered medications. The facility further failed to ensure the QAI Committee identified concerns regarding the cleaning and disinfecting glucometers (devices</p>	F0520	The facility requests to IDR F-Tag 520 with the scope and severity of an F and requests that the tag be considered for deletion or the scope and severity at a minimum be reduced. It is the policy of Miller's Merry Manor, Garrett to maintain a quality assessment and assurance committee consisting of the DON, a physician designated by the facility, and at least 3 other members of the facility's staff. The team routinely meets at least quarterly to identify	12/30/2012	

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	<p>used to assess blood sugar levels) with the potential to affect all residents in the facility receiving glucometer tests .</p> <p>Findings include:</p> <p>The facility Director of Nursing (DON) was interviewed on 11/29/12 at 9:00 A.M. During the interview, the DON indicated the QAI Committee met on a quarterly basis, or more frequently, to identify potential quality concerns. During the interview, the DON indicated the facility had a check list the nursing staff utilized to audit the medication carts and medication rooms on a monthly basis. The DON indicated the check list did not include the checking of medications for proper labeling and the QAA Committee had not identified the labeling of OTC medications as a potential concern.</p> <p>During the interview on 11/29/12 at 9:00 A.M., the DON indicated nursing staff were checked off on the use of glucometers ninety days after hire, annually, and as needed. The check off included the cleaning and disinfecting of glucometers. The DON indicated the QAI Committee had not identified the cleaning of glucometers as a potential</p>		<p>issues with respect to which quality assessment and assurance activities are necessary. Each department develops and implements appropriate plans of action to correct identified quality deficiencies. The Quality Assurance Committee has placed the deficient practice for labeling of Over the Counter Medications on a facility QA tracking log. The deficient practice only impacted 2 residents in 60 who utilized an outside pharmacy. All medication carts have been audited and all meds are properly labeled. The facility is adamant that the Quality Assurance Committee did not fail to identify concerns regarding the cleaning and disinfecting glucometers. A Quality Tool for monitoring Glucometer Use/Cleaning was already in use by the facility to monitor that infection control standards are maintained during glucometer testing since the onset of the glucometer cleaning policy in 2009. All nurses are trained on the facility protocols for infection control and the policy/procedure for glucometer cleaning at hire, the in-service director or other designee completes routine proficiency observations. The surveyors never observed the facility nursing staff to fail to clean the glucometer per policy after each observed use. The facility has implemented a verbal report</p>		

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	<p>concern.</p> <p>A policy on the Quality Assessment/Improvement Committee, dated 05/19/2006, was provided by the DON on 11/30/12 at 1:15 P.M. The policy indicated one of the functions of the QAI Committee was to "...identify potentially negative outcomes and direct the implementation of systems through actions, education, monitoring, one-on-one counseling, procedural changes, etc. to correct these potentially negative outcomes through interdisciplinary discussion." The policy further indicated the QAI Committee "will identify continued areas of needed quality control reviews."</p> <p>3.1-52(b)(1)</p>		<p>between the ongoing and oncoming nurse to communicate that the policy for cleaning/disinfecting the glucometer was indeed followed on their tour of duty. See F-Tag 431 and 441 for information on facility specific in-servicing for all nursing staff by 12/30/12. The facility identified that only residents utilizing an outside pharmacy were at risk to be affected by the improper labeling of over the counter medications. The facility only has 2 residents who utilize and outside pharmacy and were the only residents potentially or actually affected by the deficient practice. All residents who receive blood sugar monitoring are at risk to be affected by the deficient practice, but the facility maintains that no resident was placed at risk because the deficient practice does not exit nor was it observed during the annual survey process. The facility quality assurance team members will receive in-service training by the corporate nurse consultant by 12/30/12. The in-service will review the company policy/procedures for "Quality Assurance Review." Discussion regarding how the team may collect data from various sources such as open/closed record review audits, resident council/family council concerns, resident specific concerns, department specific QA</p>		

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			review tools, occurrence logs, consultant reports, survey concerns/citations, facility employees, QIS worksheets etc... The data the team collects will be utilized in an effort to determine any actual/potential negative outcomes, and to direct the facility towards practices/systems that enhance the quality of care and quality of life for the residents. Each member of the team is able to influence any necessary system change to ensure ongoing compliance. See F-Tag 431 and 441 for information on facility specific in-servicing for all nursing staff by 12/30/12. The DON or other designee will be responsible to complete the "Blood Glucose Review" (Attachment 3) on 10% of facility census per month. Any findings will be logged on facility quality assurance tracking log along with immediate actions taken. The tracking logs will be reviewed during the monthly facility quality assurance meeting to ensure ongoing compliance. The facility unit manager or other designee will be responsible to complete the "Medication Cart/Med Room Audit Review" (Attachment 2) weekly on all med carts for 4 weeks, then bi-monthly on each cart on an ongoing basis to ensure continued compliance. Any identified issues will be corrected immediately and logged on facility QA tracking log. The		

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			QA tracking logs and immediate actions taken will be discussed during the monthly Quality Assurance Meeting.	