

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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F000000	<p>This visit was for the Investigation of Complaints IN00130150 and IN000130756.</p> <p>Complaint IN00130150- Substantiated. No deficiencies related the allegation are cited.</p> <p>Complaint IN00130756- Substantiated. Federal/state deficiency related to the allegations is cited at F425.</p> <p>Survey dates: September 26 & 27, 2013</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF: 13 SNF/NF: 74 Total: 87</p> <p>Census payor type: Medicare: 17 Medicaid: 67 Other: 3 Total: 87</p>	F000000	Please accept the POC as our credible allegation of compliance.	

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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	<p>Sample: 20</p> <p>This deficiency reflects state finding cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 30, 2013, by Janelyn Kulik, RN.</p>			

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F000425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and interview the facility failed to ensure medications were disposed of in a timely manner related to lack of destroying medications or returning medications stored in the Medication Room for 1 of 3 Units. (The West Unit Medication Unit) (Residents #E, #F, #K, #M, #R, #Q, #S, #U, #V, and #W)</p> <p>The facility also failed to ensure the facility policy was followed related to the destruction of medications refused during Medication Administration Pass for 1 of 8 residents observed for the</p>	F000425	It is the policy of Millers Merry Manor - Hobart to provide pharmaceutical services to meet the needs of each residents. Residents #E, #F, #M, #K, #S, #W, #V, #R, #Q and #U were not harmed in any manner and medications were properly stored in a locked medication room awaiting disposition/return to pharmacy. Only licensed personnel have access to the keys and the locked medication rooms. On the afternoon of 9/26/13 the DON completed the drug disposition and or return of said medications to pharmacy per facility policy. The facility policy for medication storage and	10/22/2013			

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	<p>administration of medications. (Resident #P)(LPN #2)</p> <p>Findings include:</p> <p>1. On 9/26/13 at 4:15 a.m., the Medication Room on the West Unit was observed with LPN #1. There were two blue plastic bins on the counter. There were multiple rolls of resident medications in each of the bins. The rolls were randomly piled in the bins. There were rolls for at least ten different residents. The rolls all had different dates on them and different medications in each roll. There were rolls for Residents #E, #F, #M, #K, #S, #W, #V, #R, #Q, and #U. There were rolls of medication for Resident #F dated 9/22/13 thru 9/27/13. One roll contained (8) Quetiapine (an antipsychotic medication) 25 milligram pills along with multiple other medications. Multiple rolls labeled for Resident #R were dated with medication doses for 9/9/13 thru 9/11/13. There were doses of Escitalopram (an antidepressant medication) and Gabapentin (a medication for seizures) 100 milligram tablets. There were rolls of several medications for Resident #E. The rolls contained medications for the dates of 8/25/13, 8/26/13, 9/16/13, 9/18/13, and</p>		<p>disposition was reviewed with all licensed nursing/QMA's on 10/7/13. Resident P was not negatively affected by LPN #2 deficient practice. On 9/26/13 the DON completed a 1:1 in-service education with LPN # 2 regarding the proper destruction of a refused/dropped medication. All licensed nursing staff and QMA's will be in-serviced on or before 10/20/13 regarding the policy and procedure for drug disposition and the proper storage of medications. The procedure for disposing of medications using the drug buster and two licensed staff. The destruction of medication will be documented on facility disposition record. Medications returned to the pharmacy will be documented on two ply form to ensure reconciliation of medications. A copy of the form will be placed in pharmacy tote along with medications for return. The tote will be secured per protocol using zip ties and returned to pharmacy with next scheduled delivery. Each medication room will have a dedicated pharmacy tote identified to place medications awaiting return or disposition. The 3rd shift charge nurse will be responsible to complete the return/destruction of medications in the assigned tote each Monday, Wednesday, Friday. The DON or other designee will be responsible to complete the "Drug</p>				

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	<p>9/19/13.</p> <p>On 9/26/13 at 9:55 a.m., the Medication Room on the West Unit was observed with the Director of Nursing. The two blue pins were still present on the shelf with multiple rolls and bags of medications. There was a bag with roll of (9) Coumadin (a blood thinner) 2.5 milligram pills with Resident #M's name. The label on the bag indicated the order was filled on 7/29/13 with a total quantity of (14) Coumadin pills delivered. There were rolls of medications for Resident #E in one of the bins. The rolls contained a total of (35) pills dated for 9/15/13 thru 9/21/13. There were (7) Remeron (an antidepressant medication) 30 milligram tablets included in the rolls for Resident #E. There were rolls of pills for Resident #Q. There were a total (19) pills dated 9/10/13 thru 9/11/13 in the rolls.</p> <p>When interviewed on 9/26/13 at 9:55 a.m., the Director of Nursing indicated medications are removed from the Medication Carts when residents are discharged or are sent to the hospital even for a few days. The Director of Nursing indicated when the resident returns to the facility the Physician orders are updated and the pharmacy sends new medications. The Director</p>		<p>Destruction/Disposition Return Review tool" 3x weekly for 4 weeks then weekly thereafter to monitor for continued compliance. Any identified issues will be logged on QA tracking tool. All QA tracking logs are reviewed monthly during the monthly QA meeting to monitor for ongoing compliance.</p>				

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	<p>of Nursing indicated medication return disposition forms need to be made out for each medication. The Director of Nursing indicated the medications in the West Unit Medication Room should have been destroyed or returned to the Pharmacy in timely manner. The Director of Nursing indicated the facility would not be able to accurately determine if any of the medications were missing as there were several medications for multiple residents being stored in the Medication Room and not destroyed or returned to the Pharmacy in a timely manner.</p> <p>When interviewed on 9/26/13 at 4:15 a.m., LPN #1 indicated when residents are sent to the hospital or their medications are changed or discontinued they are removed from the Medication Cart and placed in the Medication Room. The LPN indicated individual return slips were to be made out for each medication. The LPN indicated Pharmacy then comes and picks up the medications.</p> <p>When interviewed via telephone on 9/27/13 at 9:00 a.m., the Pharmacy Director indicated the pharmacy delivers a seven day supply or the ordered medications weekly. The Director indicated there is a "header"</p>			

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	<p>and "footer" on the bottom of each days roll of medications. The Director indicated the "header" and "footer" contain documentation of the resident's name and room number. The Director indicated in order for credit for the medication to be given both the "header" and "footer" need to be in place on the roll showing the whole roll for that days supply of medications is intact. The Director indicated if the facility returns medications rolls without the "header" or "footer" attached the medications are not credited and the pharmacy destroys them. The Director indicated they do not require disposition forms as it was the facilities responsibility to log and keep the records. The Director indicated he did not feel the medications should be left in the container in the medication room as this posed a potential for a mistake to occur.</p> <p>2. The morning Medication Administration Pass on the West Unit was observed on 9/26/13 at 9:11 a.m. LPN #2 prepared eight oral medications for Resident #P from the Medication Cart in the hallway. The medications included one Potassium Chloride 10 meq(milliequivalent)</p>						

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	<p>tablet and one enteric coated Aspirin 81 milligram tablet. The LPN placed the medications in a small cup of applesauce and entered the resident's room with the medications. LPN #2 gave the resident the applesauce from the cup using a spoon. The resident spit out some of the medications. The LPN returned to the Medication Cart with the two pills the resident had spit out. The LPN identified the medications as a Potassium medication and an aspirin. LPN #2 then disposed of the two medications in a container on the side of the Medication Cart. The container was a closed system contained used for the disposal of syringes and needles. No other Nurse witnessed LPN #2 disposing of the two medications.</p> <p>The record for Resident #P was reviewed on 9/27/13 at 8:30 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, senile dementia, atrial fibrillation (an irregular heart rhythm) diabetes mellitus, hypokalemia (a low potassium level) high blood pressure, and coronary atherosclerosis.</p> <p>Review of the September 2013 Active Orders record indicated there were Physician orders for the resident to</p>						

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	<p>receive ASA EC (enteric coated aspirin) 81 milligrams once a day at 9:00 a.m. for a diagnosis of atrial fibrillation and Potassium Chloride (a Potassium supplement) 10 meq (milliequivalent) once a day at 9:00 a.m. for a diagnosis of hypokalemia.</p> <p>When interviewed on 9/27/13 at 9:05 a.m., the Director of Nursing indicated the facility policy was for medications to be destroyed using the "Drug Buster" which is located in the Medication Room or the Utility Room. The Director of Nursing indicated the medications are to be poured into the bottle of "Drug Buster" to be destroyed. The Director of Nursing indicated two Nurses are required to witness any medication destruction. The Director of Nursing indicated LPN #2 should not have put the medication in the container on the Medication Cart.</p> <p>The facility policy titled "Drug Buster Medication Disposal" was reviewed on 9/27/13 at 9:10 a.m. The policy was dated 4/23/2103. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated medications were to be destroyed in the Drug Buster container with two licensed Nurses present.</p>				

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	This federal tag relates to Complaint IN00130756. 3.1-25(o)				