

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155556	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 300 FAIRGROUNDS RD TIPTON, IN 46072
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey Dates: September 30, October 1, 2, 3 and 4, 2013.</p> <p>Facility number : 000505 Provider number : 155556 AIM number : 100266350</p> <p>Survey team : Michelle Hosteter, RN-TC Gloria Bond, RN Maria Pantaleo, RN Angie Patterson, RN Tom Stauss, RN</p> <p>Census bed type: SNF: 20 SNF/NF: 108 Total : 128</p> <p>Census payor type: Medicare : 23 Medicaid : 85 Other : 20 Total : 128</p> <p>These deficienices refer to state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by</p>	F000000	<p>Mrs. Tammy Alley, Please accept the following plans of correction as credible allegation of compliance to the deficiencies cited during the survey conducted here on Oct. 4th, 2013. If you have any questions or need any further information, please do not hesitate to contact me here at the facility at 765-675-8791. The facility also respectfully requests that paper compliance be considered. Sincerely, Troy Clements</p>	

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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	Tammy Alley RN on October 14, 2013.			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review the facility failed to update a care plan after a change of dialysis site for 1 of 23 residents reviewed for care plans. (Resident #107)</p> <p>Findings include :</p> <p>The record review for Resident # 107 was completed on 10/3/13 at 9:30 a.m. Diagnoses included, but were not limited to, diabetes, urinary incontinence, congestive hear failure, low potassium, chronic kidney disease (Stage V), depression, and</p>	F000279	It is the policy of Miller's Merry Manor to ensure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's needs that are identified in the comprehensive assessment process. All residents undergoing dialysis in the facility have the potential to be affected by the deficient practice. All care plans of residents undergoing dialysis treatment have been reviewed to ensure the correct dialysis site is listed on the care plan. To prevent recurrence of the deficient practice, all nurses that	11/08/2013	

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	<p>hypothyroidism and hemolytic anemia.</p> <p>The resident had a care plan dated 4/13/13 for dialysis. The care plan for the dialysis site indicated , "...Assess bruit and thrill each shift or as ordered...Observe for signs and symptoms of infection to shunt site...."</p> <p>In an interview with the RN #10 at 2 p.m., on 10/3/13, she indicated that Resident #107's dialysis access site was on the right upper chest area.</p> <p>The Treatment Administration Record for October 2013 indicated, No blood pressures, labs or sticks in right arm.</p> <p>The Director of Nursing indicated on 10/3/13 at 2:40 p.m., the care plan did not reflect the current dialysis site.</p> <p>3.1-35(a)</p>		<p>are involved in the care plan process will be in-serviced on the Care Plan Development and Review Policy (Attachment 1-A) on 11/7/13. The DON or designee will complete the Care Plan Review QA Tool (Attachment 2-A) for all residents undergoing dialysis treatment. This will be completed weekly for 4 weeks, monthly for 5 months and quarterly thereafter for ongoing compliance. Any concerns will be corrected immediately, logged on the facility QA tracking log and reviewed in the monthly QA meeting, along with any new recommendations implemented. Corrective actions will be completed by 11/08/13.</p>		

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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 observation, interview and record review , the facility failed to ensure physician orders were followed for blood pressures (Resident #105) and failed to ensure care plans were followed for fall interventions (resident #76) for 2 of 35 residents reviewed for following the residents plan of care.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the medication pass observation on 10/1/2013 at 9:55 A.M., Resident #105 received the blood pressure and heart medication metoprolol tartrate 75 mg (milligrams) by mouth. LPN #15 was observed administering the medication to the resident without first taking her blood pressure. <p>During an interview with LPN #15 immediately following the medication pass, she indicated she had not taken Resident #105's blood pressure earlier and that no one else had taken the vital signs for the resident earlier that day. LPN #15 indicated vital</p>	F000282	<p>It is policy of Miller's Merry Manor that the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. All residents in the facility have the potential to be affected by the deficient practice; however, none of the residents involved in the identified deficient practice experienced any negative side effects or outcome. The MAR of resident # 105 was immediately updated so that nurse staff is aware they need to assess and document the resident's B/P prior to administration of the medication. All other medication orders have been reviewed and compared with the MARs to ensure there is sufficient space to record vital signs when ordered. The CNA sheet of resident # 76 was updated as of 10/22/13 to ensure that staff is aware that his walker must be kept in reach at all times. All other CNA sheets have been compared to fall interventions listed on the care plans of all residents within the facility to ensure staff is made aware of all interventions in place. To prevent recurrence of the deficient practice, all nurses will</p>	11/08/2013			

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	<p>signs were done periodically sometimes once per week.</p> <p>Resident #105's record review was completed on 10/3/2013 at 11:20 A.M. The physician's orders for October 2013 indicated, "...Metoprolol Tar 75 mg [milligrams] one 25 mg & one 50 mg by mouth 2 X daily at 10 AM and 8 PM; hold is [sic] SBP [systolic blood pressure] is less than 100DX: CAD (Coronary Artery Disease).... "</p> <p>During an interview with the Director of Nursing (DON) on 10/3/2013 at 11:12 A.M., she indicated the residents were to have their vital signs, such as blood pressure taken before blood pressure medication were administered, especially if they had parameters as part of their physician's order.</p> <p>Record review of the facility's, "General Procedures to Follow For All Medications" dated 6/1/2011, indicated, "...i. Obtain and record any vital signs as necessary prior to medication administration...."</p> <p>Record review on 10/3/2013 at 11:30 A.M., of the facility's, " Medication Administration Procedure" dated 4/10/2012, indicated to keep</p>		<p>be in-serviced on the Medication Administration-General Guidelines Policy (Attachment 1-B) on 11/7/13. Also, all nursing staff involved in the care plan process will be in-serviced on the Fall Management Procedure (Attachment 2-B) on 11/7/13. The DON or designee will complete the Fall Risk Management Review QA Tool (Attachment 3-B) for all residents that sustain a fall. This will be completed daily for 30 days, weekly for 4 weeks, and monthly thereafter. The DON or designee will also complete the Medication/MAR Review (Attachment 4-B) weekly for 4 weeks, monthly for 5 months and quarterly thereafter. Any concerns will be corrected immediately, logged on the facility QA tracking log and reviewed in the monthly QA meeting, along with any new recommendations implemented. Corrective actions will be completed by 11/08/13.</p>		

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	<p>medications that require special nursing assessments in a separate cup and to complete necessary assessments before administering medications.</p> <p>2. During observation of Resident #76 on 10/1/13 at 9:14 a.m., his walker was observed against the wall in his room out of his reach.</p> <p>During an interview with CNA #32 on 10/2/13 at 1:40 p.m., CNA # 32 indicated the resident had fallen previously and was encouraged by staff to use his walker.</p> <p>On 10/2/13 at 2:42 p.m., during an interview, LPN #33 indicated staff encouraged Resident #76 to use call light and to use his walker.</p> <p>Resident #76's record review was completed on 10/2/13 at 1:26 p.m. The resident's diagnoses included, but were not limited to, senile dementia; dysarthria; muscle weakness; blindness and low vision; and other cerebellar ataxia.</p> <p>Fall investigations from 2/2013 to present were as follows: Fall 5/31/13 at 12:20 p.m., with identified intervention non skid strips and non skid socks. Fall on 6/25/13 at 8:45</p>				

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	<p>p.m., with intervention of physical therapy screen. Fall on 8/13/13 at 4:00 p.m., with noncompliance with interventions, i.e., call for assistance, alarm. Fall on 9/13/13 at 4:30 p.m., with interventions encourage to ambulate with assistance & get out of bed for exercise.</p> <p>The care plan, updated 9/6/13, indicated the focus was fall risk. Interventions for this care plan included, but were not limited to the following: Encourage activity and ambulating to strengthen gain and muscles, keep walker within reach at all times, encourage to use walker for all transfers; ensure environment is free of clutter; Non-skid strips at bedside, sensor (key) alarm to bed (res. refuses). Use gait belt for ambulation and transfers (res. refuses).</p> <p>Fall management procedure was received from the Director of Nursing on 10/3/13 at 3:45 p.m. This current policy indicated the following: "Purpose...to assess all residents for risk factors that may contribute to falling and to provide planned interventions identified by the team as appropriate for resident use in maintaining or returning to the highest level of physical, social, and</p>				

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	<p>psychosocial functioning as possible. A procedure of "Update the plan of care each time there is a change in intervention and communicate it to staff." was listed as a procedure related to this purpose. The "Post Fall Investigation" section included "Determine if previously implemented interventions are in need of revision or discontinuation." and "Determine what new or revised interventions will be implemented to reduce the risk of further falls and / or injuries from falls."</p> <p>3.1-35(g)(2)</p>			

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure pressure ulcer care was provided to prevent further injury and to prevent the possibility of infection for 1 of 1 wound care observations. (Resident #3)</p> <p>Findings include:</p> <p>On 10/03/2013 at 10:55 a.m., Resident #3's dressing change was observed. RN #16 was observed to remove the Tegaderm (transparent dressing) using the tape method. RN #16 was observed to remove the dressing at an angle from the right lower buttock. During this dressing removal observation, Resident #3 was heard to moan and at the same time red drainage was observed from the right lower buttock area. LPN #9, who assisted with the dressing</p>	F000314	It is policy of Miller's Merry Manor that based on a comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. All resident's receiving treatment for a wound is at risk for this deficient practice. The treatment for Resident #3 was immediately changed when the injury occurred and has not sustained injury since the update. To prevent recurrence of this deficient practice all nursing staff will be in-serviced on the Pressure Ulcer Treatment Policy (Attachment 1-C) and Clean Dressing Procedure (Attachment 2-C) on 11/7/13. Each nurse is to	11/08/2013			

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	<p>change, was observed to apply pressure to the area with a 4 by 4 gauze to stop the red drainage flow. Next, RN #16 was observed to remove her soiled gloves, reapplied new gloves, and proceeded to cleanse, pack, and reapply a smaller transparent dressing to the coccyx area. No hand washing or hand sanitizing was observed between the glove changes.</p> <p>Resident #3's clinical record was reviewed on 10/3/2013 at 10:00 a.m. The resident's diagnoses included, but were not limited to, hypertension, congestive heart failure, atrial fibrillation, depression, and arthritis. The pressure ulcer was originally identified on 4/3/13, and was designated as a stage 3.</p> <p>The care plan indicated a "focus" for Wound: actual skin breakdown, location, coccyx. Interventions included, but were not limited to, monitor for pain and administer pain medications as ordered, nurse to measure/assess weekly, administered treatment as ordered, and provide with pressure reducing device to chair.</p> <p>On 10/04/2013 at 10:15 a.m., RN #16 provided the manufacturers</p>		<p>be observed and checked off to validate their understanding of the application of these policies using the Dressing Change/Treatment Procedure check off (Attachment 3-C). The DON or designee will complete the Pressure Ulcer Risk and Treatment QA Tool (Attachment 4-C) for all residents that require wound treatment. This will be completed weekly for 4 weeks, and monthly thereafter. No fewer than 10 nurses, from all shifts, will be selected to observe and check off for dressing change/treatment procedures. Results of all skills validations checks, including random observations, will be discussed at monthly QA committee meetings and any identified trends or new concerns will be addressed by the committee appropriately. Any concerns will be corrected immediately, logged on the facility QA tracking log and reviewed in the monthly QA meeting, along with any new recommendations implemented. Corrective actions will be completed by 11/08/13.</p>				

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	<p>instructions for removal of a transparent dressing. Manufacturers instructions for tape method indicated, "...removing dressing at an angle will pull at the epidermis, increasing risk of mechanical trauma..."</p> <p>Interview on 10/04/2013 at 10:15 a.m., with RN #16 indicated a smaller tegaderm should be used to help prevent any further skin tearing. She indicated that she would update the treatment record to indicate the use of a smaller tegaderm.</p> <p>A policy titled "Hand Washing and Hand Asepsis" dated 12/14/12 was provided by the Director of Nursing on 10/5/13 at 11 a.m. The policy indicated, " ...2. PROCEDURE ...D. Angle arms down holding hands lower than elbows. Wet hands and wrists. Rub vigorously for at least 20 seconds ...3. A. SPECIFIC TIMES HANDS MUST BE WASHED: 1. Before and after each shift worked. II. Before and after direct resident contact. III. Before and after handling of food ...ALCOHOL BASED ANTISEPTIC CLEANSER MAY BE USED DURING MEDICATION PASS ... Hands should be washed with soap and water during meal service if there is direct hands-on contact with</p>			

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	resident(s). Adjusting positioning, touching the residents face, etc " 3.1-40(a)(2)			

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F000371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to maintain a clean kitchen and staff failed to wash their hands when indicated and for the appropriate amount of time for 1 of 2 kitchen observations.</p> <p>Findings include:</p> <p>1. RN #14 was observed handwashing at 12:16 p.m., for only 7 seconds as she prepared to serve residents meal trays.</p> <p>2. During a second dining observation of the second floor dining room, on 10/2/13 at 12:26 p.m., CNA #21 was observed to pick up 2 pats of butter and place them on an unidentified resident's plate with bare hands and then served the plate to the resident.</p> <p>CNA #37 was observed entering the dining room at 1:00 p.m., and did not wash her hands before serving juice</p>	F000371	Please accept the following plan of correction as credible allegation of compliance to the deficient practice cited under tag F371, of which all residents in the facility had the potential to be affected by. It is the policy of Miller's Merry Manor to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. None of the residents involved in the identified deficient hand washing practice experienced any negative side effects or outcomes. An all staff in-service will be held on 11/7/2013 which include the review of our Handwashing Policy and Procedure (3-D). At this in-service, all staff, including the staff members identified in this finding, will be observed while handwashing and checked off after they successfully demonstrate their understanding of this policy and procedure. To ensure on-going compliance with this correction, the Infection Control Nurse, In-service director,	11/08/2013			

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	<p>to resident #23.</p> <p>3. During a kitchen observation on 9/30/13 at 9:51 a.m., Dietary Aide #13, was observed to have picked up a crate off of the floor, then touched the silverware. At 9:58 a.m., Dietary Aide #13 went into the cooler and placed the food supplies in the cooler, came out of the cooler, and got the plates and prepared the ice cream by scooping it into the bowls without hand washing.</p> <p>During the same kitchen observation, Dietary aide #13 was observed handwashing for less than 15 seconds and turned the water off with wet hands.</p> <p>Dietary aide #13, touched a soiled paper towel, threw the towel in the trash, and then prepared broth without handwashing.</p> <p>4. On 09/30/2013 at 11:58 a.m., CNA #21 was observed to handwash for less than 20 seconds on the first floor back dining room. The timer above the handwashing sink was observed not to be used. She was observed to continue to pass meal trays.</p> <p>On 10/02/2013 at 12:49 p.m., Social Services Director (SSD) was</p>		<p>or other designee will be responsible for completing the QA Tool entitled "Infection Control Review" (Attachment 1-D) weekly for 4 weeks then monthly for 2 months and quarterly thereafter, whereas no fewer than 10 facility employees, including employees from all shifts, will be selected to observe and check off on their handwashing practices. The Dietary Manager, or designee, will also conduct hand washing audits weekly for 4 months then monthly thereafter, documenting her findings on the QA Tool entitled "Dietary Food Safety Sanitation Checklist" (Attachment 2-D). Results of these reviews will be discussed at monthly QA committee meetings and any new identified trends or concerns will be addressed by the committee as appropriate. Any concerns identified during infection control skills observations will also be addressed individually at the time of occurrence.</p>		

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	<p>observed to handwash for less than 20 seconds while in first floor back dining room. The timer above the handwashing sink was observed not to be used. She was observed to continue to pass meal trays.</p> <p>A review of the Dietary department's handwashing policy was completed on 10/4/13 at 11:03 a.m. The current policy indicated: "...It is policy that all dietary employees know and understand when handwashing is required and how to properly wash their hands...." Current procedures for this policy included "...employees shall wash their hands and exposed portions of their arms at the following times...after handling soiled surfaces equipment or utensils...to prevent cross contamination when changing tasks...after engaging in other activities that contaminate the hands...." Also according to current facility policy, proper handwashing included "...rub hands vigorously together for 20-30 seconds with attention paid to areas underneath the fingernails and between the fingers...dry hands using a paper towel...use a paper towel to turn off the faucet and dispose of the towel."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>						

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F000372 SS=D	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation and record review, the facility failed to ensure the garbage container lids were closed when not in use for 2 of 2 kitchen observations of the 2nd floor satellite kitchen.</p> <p>Findings include:</p> <p>An observation of the second floor satellite kitchen was completed on 9/30/13 at 12:16 p.m. The garbage can near the handwashing sink in the 2nd floor satellite kitchen was observed to be overflowing and the lid was open.</p> <p>An observation of the second floor satellite kitchen was completed on 10/2/13 at 12:23 p.m. The lid on the garbage can was observed to be open.</p> <p>A facility policy, "Garbage and Refuse" was provided on 10/3/13 at 11:10 a.m., by the Dietary Manager indicated, "...It is policy that effective measures shall be utilized for protection against rodents, flies, cockroaches, and other insects...Trash cans are clean and</p>	F000372	<p>Please accept the following plan of correction as credible allegation of compliance to the deficient practice cited under tag F372, of which all residents in the facility had the potential to be affected by. It is the policy of Miller's Merry Manor that all trash cans are kept clean and that the lids are kept shut to protect against rodents, flies, cockroaches and other insects. To correct this deficient practice, all dietary staff will be re-inserviced on our policy entitled Garbage and Refuse (Attachment 1-E). To prevent recurrence, the Dietary Manager, or designee, will complete an inspection of food preparation and service areas daily for 2 weeks, weekly for 1 month and monthly thereafter. Their findings will be documented on the QA Tool entitled "Dietary Food Safety Sanitation Checklist" (Attachment 2-D). Results of these audits will be discussed during our monthly QA Committee Meetings. Furthermore, if concners are noted during these inspections, individual counselling/discipline will be conducted as appropriate.</p>	11/08/2013			

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	<p>have lids on....."</p> <p>3.1-21(i)(5)</p>			

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F000431 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, interview and record review, the facility failed to ensure that medications that were expired, or open and undated were</p>	F000431	It is the policy of Miller's Merry Manor that all drugs and biological used within the facility are labeled in accordance with currently accepted professional	11/08/2013			

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	<p>removed from stock for 2 of 3 medication rooms and 2 of 6 medication carts observed.</p> <p>Findings include:</p> <p>During the medication storage observation on the following dates and times medications were found to be expired, or not dated when opened:</p> <p>1. Orchard unit: 10/3/13 at 9:40 a.m., with LPN # 1: Ativan vial had an open date of 6/2/13 and an expiration date of 9/2/13. At this time, LPN # 1 indicated during interview the Ativan was only good for 90 days.</p> <p>2. Second floor medication room on 10/3/13 at 9:55 a.m., with LPN # 9: Ativan vial had been opened with no open date or expiration date. At this time, LPN # 9 indicated the Ativan should be destroyed since she was unsure of the open date.</p> <p>3. Terrace unit medication cart on 10/3/13 at 3:19 p.m., with LPN # 17: Lantus insulin had an open date of 8/9/13 and a bottle of eye drops and open date of 4/26/13. At this time, LPN # 17 indicated insulin expired 28 days after it is opened and eye drops expire 90 days after opening.</p>		<p>principles. This must include appropriate accessory and cautionary instructions, and the expiration date when applicable. All residents within the facility have the potential to be affected by this practice. All medications in the facility have been inspected as of 10/7/13 to ensure that an open date is present and that no medications are stored past the expiration date. All nurses will be in-serviced on the policy entitled Storage of Medications (Attachment 1-F) on 11/7/13. To prevent recurrence of this deficient practice, the DON or designee will complete the QA audit tools entitled Medication Cart Audit (Attachment 2-F) and Medication Room/Refrigeration Storage Review (Attachment 3-F) weekly for 4 weeks and then monthly thereafter. New concerns will be corrected immediately, logged on the facility QA tracking log and reviewed in the monthly QA meeting. Corrective action will be completed by 11/8/13.</p>		

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	<p>4. Garden unit medication cart on 10/3/13 at 4:45 p.m., with LPN # 9: 2 boxes of Atrovent inhalation treatments were opened and undated. 1 Combivent inhaler was opened and undated. At this time LPN # 9 indicated that the inhalation treatments that are open and undated need to be thrown away.</p> <p>On 10/3/2013 at 3:45 p.m., the Director of Nursing (DON) provided a policy on medication storage. The policy indicated "...outdated, contaminated, or deteriorated medications...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>3.1-25(j)</p>				

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F000441 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. Based on observation, interview, and record review, the facility failed to</p>	F000441	It is the policy of Miller's Merry Manor to establish and maintain	11/08/2013			

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	<p>ensure staff were following sanitation guidelines in regards to safe linen handling, sanitary procedures when handling tube feeding, and handwashing practices for 4 of 4 observations for infection control procedures. (Resident #5)</p> <p>Findings include:</p> <p>1. An observation with the Director of Nursing (DON) on 10/1/13 at 10:23 a.m. of Resident # 5's tube feeding tubing, the tip of the tube feeding tubing was hanging over the top of the tube feed bottle and did not have a cover on it. In an interview with the Director of Nursing at that time, she indicated they are to either cover the tip or throw the tube feeding away. She wasn't sure what the policy was so she would check.</p> <p>The DON indicated in an interview on 10/1/13 at 10:45 a.m.,that RN #10 indicated there was a cover for the tip and she did not know where it was.</p>		<p>an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. All residents within the facility have the potential to be affected by this practice. None of the residents involved in the identified deficient practice or experienced any negative side effects or outcome. All nursing staff will be in-serviced on 11/7/13 which will include the review of Medication Administration Procedure (Attachment 1-G), Hand Washing and Hand Asepsis Policy (Attachment 3-D) and Procedure and the Linen Handling Policy (Attachment 2-G). Each staff member is to be observed and checked off to validate their understanding of the application of these policies. To ensure ongoing compliance with the corrections, the Infection Control Nurse, Director of Nursing or other designee will be responsible for completing the the QA Tool entitled "Infection Control Review"(Attachment 3-G) weekly for 4 weeks then monthly for 2 months and quarterly thereafter, whereas no fewer than 10 facility employees, including employees from all shifts, will be selected to observe and check off for infection control practices. Results of all skills validations checks, including random infection control observations, will</p>		

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	<p>2. During a medication pass observation on 10/1/2013 at 9:55 A.M., LPN #15 was observed not sanitizing or washing her hands before or after a medication pass.</p> <p>A policy titled " General Procedure To Follow For All Medications" dated 6/11, and another policy titled "Medication Administration Procedure" dated 10/4/12, was provided by the Director of Nursing on 10/3/2013 at 11:30 a.m. The policy indicated to cleanse hands before handling medication and before contact with a resident. In addition the policy indicated to perform hand hygiene after the resident has taken the medication.</p> <p>3. In an observation on 10/4/13 at 11:00 A.M., a visitor was observed</p>		<p>be discussed at monthly QA committee meetings and any identified trends or new concerns will be addressed by the committee appropriately. Any concerns identified during infection control skills observations will also be addressed individually at the time of the occurrence. Corrective action will be completed by 11/8/13.</p>		

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	<p>placing clothing protectors on the dining room tables in the the main dining room. The visitor was observed holding the clothing protectors up to her personal clothing. The Dining Manager was present and gave no instructions regarding proper procedure regarding handling of clothing protectors when asked by visitor if she could help with clothing protectors.</p> <p>4. On 09/30/2013 at 12:08 p.m., Housekeeper #20 was observed carrying clean laundry against her body into a an unidentified resident's room.</p> <p>3.1-18(l) 3.1-19(g)</p>				