

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2012
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN46158
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 9, 10, 11 &amp; 12, 2012.</p> <p>Facility number: 000398 Provider number: 155564 AIM number: 100291110</p> <p>Survey team: Marcy Smith, RN-TC Leia Alley, RN Dinah Jones, RN</p> <p>Census bed type: SNF/NF: 54 SNF: 20 Total: 74</p> <p>Census Payor Type: Medicare: 20 Medicaid: 39 Other: 15 Total: 74</p> <p>Sample: 15</p> <p>These deficiencies also reflect State findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 13,</p>	F0000	The Mooresville facility respectfully requests paper compliance. Please accept the following plan of correction for F-Tag 282, F-Tag 371, and F-Tag 514 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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F0282 SS=D	<p>2012 by Bev Faulkner, RN</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 interview and record review, the facility failed to obtain blood work as ordered by a physician, for 1 of 8 residents reviewed for laboratory services in a total sample of 15 residents. Resident #36.</p> <p>Findings Include:</p> <p>The record for Resident #36 was reviewed on 1/10/12 at 10:00 a.m.</p> <p>Diagnoses for Resident #36 included but were not limited to, atrial fibrillation (a common type of abnormal heartbeat in which the heart rhythm is fast and irregular).</p> <p>A physicians order was written on 1/2/12 that indicated the facility was not to give Resident #36 their blood thinning medication for four days and then obtain a laboratory drawing for "PT/INR [They are blood tests used to determine the clotting tendency of blood] on Friday 1-6-12".</p> <p>During an interview with the DON (Director of Nursing) on 1/11/12 at 5:45 p.m., she indicated that the blood work for</p>	F0282	<p><b>F 282</b></p> <p>All residents with PT INR's on Coumadin were check on 1/11/12 with zero missed labs. All other resident's labs were checked to ensure no deficient practices were found. All other labs were completed per physicians order.</p> <p>Preventative measures taken: 1.) Lab tracker tool initiated on all units to monitor all labs ordered. Will be completed by the nurse on duty and audited by unit managers on an on-going basis. (Attachment A) 2.) Labs QA tool (Attachment B) 5 resident per week will be audited by DON or designee 1 time a week for 4 weeks, then monthly for 5 months, then quarterly thereafter. If any problems are identified we will address them immediately and expand the audit to all residents that could be affected. 3.) In-serviced Nursing Staff on Jan 20, 2012 (Attachment C)</p>	01/27/2012	

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F0371 SS=F	<p>Resident #36 was not done on 1/6/12. She indicated the next time the PT/INR lab work was done was on 1/9/12.</p> <p>A facility policy and procedure was requested on 1/12/12 at 1:00 p.m., from the facility Administrator. The DON indicated there was not a certain policy and procedure for laboratory blood work.</p> <p>3.1-35(g)(2)</p> <p>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</p> <p>Based on observation, record review and interview, the facility failed to ensure facial hair was covered and food was served in a sanitary manner to residents in the dining room who required assistance with their meals. This had the potential to affect 74 of 74 residents who consumed food from the kitchen and 17 of 17 residents who required assistance with their meals in the dining room.</p> <p>Findings included:</p> <p>1. During a kitchen tour with the Dietary Manager (DM) on 1/9/12 at 10:35 a.m., he was not wearing a facial hair covering over his goatee. On 1/9/12 at 12:00 p.m.,</p>	F0371	<p><b>F 371</b></p> <p>All nursing staff was in-serviced on the facility Hand Washing Policy &amp; Procedure on Jan 20, 2012. (Attachment C&amp;D)</p> <p>Only one employee requires the use of beard net in the dietary department. Employee has been counseled on beard net requirements and now wears one at all times when in the kitchen.</p> <p>Preventative measure taken: 1.) Feeding procedure QA tool (Attachment E) 3 employees per week will be audited by DON or designee 1 time a week for 4 weeks, then monthly for 5 months, then quarterly thereafter.</p>	01/27/2012	

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	<p>the DM was bending over the steam table checking food temperatures. He was not wearing a facial hair covering over his goatee. On 1/12/12 at 12:15 p.m. and 12:28 p.m., while food was being served, he entered and walked through the kitchen. He was not wearing a facial covering over his goatee at these times.</p> <p>During an interview with the DM on 1/12/12 at 9:40 a.m., when asked about wearing a facial hair covering for his goatee, he indicated "No one has ever told me this before."</p> <p>Review of a facility policy dated March, 2009, received from the Administrator on 1/12/12 at 1:00 p.m., titled "Personal Hygiene," indicated ...3. Hair restraints that completely cover the hair are to be worn at all times in the department to prevent hair from falling onto food and kitchenware...Facial hair must be covered by a beard restraint..."</p> <p>2. During an observation of the lunch meal in the dining room on 1/10/12 at 12:20 p.m., the following was observed:</p> <p>CNA #1 (Certified Nursing Assistant) was feeding Resident #61. She then moved to another table and began feeding Resident #44, whose head was bowed and eyes were closed. She wiped Resident #44's</p>		<p>Any problems identified will be addressed immediately</p> <p>2.) Beard net QA tool will be monitored by Administrator or designee 1 time a week for 4 weeks, then monthly for 5 months, then quarterly thereafter. (Attachment F). Any problems identified will be addressed immediately.</p>		

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	<p>mouth with her clothing protector, touched the resident's face with her left hand to get her attention and held a glass of milk to her mouth. She then touched Resident #44's shoulder with her right hand, scratched her own back under her collar with her left hand and touched the resident's neck with her right hand. She tilted the resident's chin up with her right hand and placed some food in her mouth. At 12:25 p.m., she moved to another table and handed a cup of hot chocolate to Resident #58. She returned to Resident #44 and again wiped her chin with her clothing protector, lifted her chin gently urging her to eat. She then moved to another table and handed Resident #25 a cup of hot chocolate. At 12:35, she began helping Resident #25, touching the back of the resident's head/hair with her bare hand, urging her to keep her head down and feeding her. She then returned to Resident #44, then went back to Resident #25, again placed her hand on the back of the resident's head reminding her to "keep your head tucked." She then returned to Resident #44, fed her some ice cream and wiped her mouth with her clothing protector. At no time was she observed washing her hands or using hand sanitizer.</p> <p>During and interview with CNA #2 on 1/10/12 at 6:05 p.m., she indicated "If we're feeding 2 people at once we use 1</p>				

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	<p>hand for each resident. If we touch something we're supposed to rewash our hands or sanitize them."</p> <p>During an interview with the Assistant Director of Nursing on 1/10/12 at 6:06 p.m., she indicated when staff feed residents they should "wash their hands, designate 1 hand for each resident. If hands or residents intermingle, they need to rewash their hands."</p> <p>During an interview with the Dietary Manager on 1/12/12 at 9:40 a.m., he indicated there were 17 residents in the dining room who needed assistance with their meals.</p> <p>Review of a facility policy, dated 6/9/10, received from the Director of Nursing (DoN) on 1/11/12 at 11:30 a.m., titled "Subject: Hand Washing and Hand Asepsis," indicated "1. Policy: To provide protection for resident and staff when performing direct care procedure. To ensure that hands remain clean so as to assist in maintenance of a clean environment and assist in the prevention of and the transmission of disease and infection...A. Specific times hands must be washed:...II. Before and after direct resident contact...5. Hands should be washed with soap and water during meal service if there is direct hands-on contact</p>				

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F0514 SS=D	<p>with resident(s)..."</p> <p>Review of a facility policy, dated 1/3/2001, received from the DoN on 1/11/12 at 11:30 a.m., titled "Feeding Dependant[sic] Resident Procedure" indicated "...C. Procedure...11. If feeding more than one resident at a time - be sure to use alcohol gel when you have touched a resident."</p> <p>3.1-21(i)(3)</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure records were accurately maintained for documentation of Accuchecks (a finger stick test measuring blood sugar) for 1 of 2 residents reviewed for documentation of Accuchecks in a sample of 15. (Resident #40)</p> <p>Findings included:</p>	F0514	<p><b>F 514</b></p> <p>In-service held on 1-20-12 for proper documentation (reviewed Injection Subcutaneous Procedure - Attachment G). The MARS &amp; TARS for all current residents were audited to determine that there were no other medications or treatments that had not been properly initialed.</p> <p>Preventative action taken</p>	01/27/2012	

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	<p>The record of Resident #40 was reviewed on 1/10/12 at 1:30 p.m.</p> <p>Diagnoses for Resident #40 included, but were not limited to, diabetes mellitus and end stage renal disease.</p> <p>Recapitulated physician's orders for December, 2011, indicated Resident #40 was to have her blood sugar checked at 6:00 a.m. and 11:00 a.m. (original order date 4/28/11) and 4:00 p.m. and 9:00 p.m. (original order date 4/15/11). These orders indicated she was to receive Novolog insulin at 6:00 a.m., 11:00 a.m. and 4:00 p.m. according to the following sliding scale:</p> <p>Blood sugar (BS) of 140-159 = 1 units of insulin            BS of 160 - 179 = 2 units            BS of 180 - 199 = 3 units            BS of 200 - 219 = 4 units            BS of 220 - 239 = 5 units            BS of 240 - 259 = 6 units            BS of 260 - 279 = 7 units            BS of 280 - 299 = 8 units            BS of 300 - 319 = 9 units            BS of 320 - 339 = 10 units            BS of 340 - 359 = 11 units            BS of 360 - 379 = 12 units            BS of 380 - 400 = 13 units</p> <p>A review of the Medication</p>		<p>1.) MARS &amp; TARS QA tool (Attachment H) 10 residents per week will be audited by DON or designee 1 time a week for 4 weeks, then monthly for 5 months, then quarterly thereafter. Any problems identified will be addressed immediately.</p>		

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	<p>Administration Record for December, 2011, did not indicate Resident #40 received any sliding scale insulin at the following times"</p> <p>12/14/11 at 6:00 a.m. BS = 156. She should have received 1 unit.</p> <p>12/18/11 at 6:00 a.m. BS = 162. She should have received 2 units.</p> <p>12/25/11 at 6:00 a.m. BS = 153. She should have received 1 unit.</p> <p>12/27/11 at 6:00 a.m. BS = 152. She should have received 1 unit.</p> <p>12/29/11 at 6:00 a.m. BS = 142. She should have received 1 unit.</p> <p>12/16/11 at 11:00 a.m. BS = 162. She should have received 2 units.</p> <p>12/19/11 at 11:00 a.m. BS = 185. She should have received 3 units.</p> <p>12/22/11 at 11:00 a.m. BS = 176. She should have received 2 units.</p> <p>Further information was requested from the Director of Nursing (DoN) on 1/10/12 at 5:15 p.m., regarding the above blood sugar results which should have received sliding scale insulin. On 1/11/12 at 11:30 a.m., the DoN indicated she had spoken with the nurses who were caring for Resident #40 on the above days and they indicated they had given the sliding scale insulin injections but had forgotten to document them. She indicated the nurses should have documented the amount of insulin they gave.</p>			

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	<p>Review of a facility policy, dated 3/21/11, titled " Injection - Subcutaneous Procedure," received from the DoN on 1/11/12 at 2:35 p.m., indicated "...37.. Document initials on the administration record..."</p> <p>3.1-50(a)(1)</p>				