

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 07/21/2015 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|------------------------|--|--------|--|--|
| F 0000 Bldg. 00 | <p>This visit was for the Investigation of Complaints IN00176024 and IN00177307.</p> <p>Complaint IN00176024-Substantiated. Federal/State deficiency related to the allegations was cited at F332.</p> <p>Complaint IN00177307-Substantiated. No deficiencies related to the allegations were cited.</p> <p>Survey dates: July 20 & 21, 2015.</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Census by bed type: SNF: 11 SNF/NF: 69 Total: 80</p> <p>Census payor type: Medicare: 12 Medicaid: 55 Other: 13 Total: 80</p> <p>Sample: 4 Supplemental sample: 2</p> | F 0000 | | |
|------------------------|--|--------|--|--|

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 07/21/2015 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 0332 SS=D Bldg. 00 | <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 3 residents observed during 3 medication pass observations. 5 errors in</p> | F 0332 | It is the policy of Miller's Merry Manor Hoabart to ensure that it is free from medication error rates of five percent or greater. LPN #1 and LPN #2 have received 1:1 re-education regarding | 08/07/2015 | |

| | | | |
|--|---|--|---|
| 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 07/21/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>medications were observed during 28 opportunities for errors in medication administration. This resulted in a medications error rate of 17.85%. (Residents #F and #G)</p> <p>Findings include:</p> <p>1. During an observation of the morning medication administration pass on 07/20/15 at 8:06 a.m., LPN #1 prepared Resident #F's morning medications, which included, sucralfate (stomach medication) 1 gm (gram), one tablet, lansoprazole suspension (stomach medications), 10 ml (milliliters), and loratadine-pseudoephedrine 10-240 mg (milligrams) (allergy medications), one tablet.</p> <p>LPN #1 checked the medications with the Medication Administration Record (MAR), then place the sucralfate 1 gm into the plastic medication cup.</p> <p>LPN #1 poured the lansoprazole suspension into a plastic cup and measured out 5 ml's.</p> <p>LPN #1 indicated the resident's loratadine-pseudoephedrine was not available in the medication cart and she would need to retrieve the medication from the "Pyxis" (machine in the building</p> | | <p>medication administration and the importance of following the resident specific physician's orders. LPN # 1 and LPN #2 have participated in a return demonstration medication pass observation completed by In-service Director. Resident F and G: MD was notified of medication errors and neither resident experienced any negative effects. Physicians orders for resident F and G will be followed as ordered. All residents are risk to be affected by the deficient practice. The facility nurse managers completed an audit 7/31/2015 of each residents physicians orders and available medications to ensure availability of medications ordered by physicians. All licensed nursing staff will be in-serviced by 8/7/15 on facility policy and procedures for "Medication Pass Administration Procedure", and ensuring medications are administered in accordance with the orders of the attending physician. All newly hired charge nurses participate in an 11 day orientation process which requires a return demonstration of proper medication pass procedures. The pharmacy consultant makes monthly visits and participates in medication pass observations to ensure competency. The nurse managers participate routine walking rounds of unit and will</p> | |

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| 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 07/21/2015 | |
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>which dispenses medications for emergency use), and prepared the other medications ordered for administration.</p> <p>LPN #1 then indicated she had poured out 10 ml's of the lansoprazole, then looked again at the medication cup and indicated there was only 5 ml's in the medication cup.</p> <p>LPN #1 then administered the medications to the resident. Resident #F had not received the loratadine-pseudoephedrine with the morning medications.</p> <p>Resident #F's record was reviewed on 07/20/15 at 9:16 a.m. The resident's diagnoses included, but were not limited to, esophageal reflux disease and congestive heart failure.</p> <p>The Physician's Recapitulation Orders, dated 07/20/15, included, sucralfate, give one tablet by mouth before meals for stomach ulcers at 7 a.m., 11 a.m., and 4 p.m., lansoprazole suspension, give 10 ml's by mouth daily, and loratadine-pseudoephedrine ER (extended release), 10-240 mg, give one tablet one time daily at 8 a.m.</p> <p>During an interview on 07/20/15 at 9:16 a.m., LPN #1 indicated she, "assumed"</p> | | <p>make visual observations to ensure policy and procedures for medication administration are followed. The in-service director or other designee will be responsible to complete "Medication Pass Procedure Tool" (Attachment A) quarterly with all charge nurses on an ongoing basis to monitor for ongoing compliance. Any issues identified during observation will be immediately corrected and documented on the facility quality assurance tracking tool. The facility reviews all tracking logs during the monthly Quality Assurance meeting to monitor ongoing compliance.</p> | | | | |

| | | | | | |
|--|--|---|---|----------------------|---|
| 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 07/21/2015 |
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>the resident had already ate breakfast prior to the administration of the sucralfate. LPN #1 indicated the resident had his breakfast in the dining room. LPN #1 indicated she was getting report at 7 a.m. and had not given the sucralfate as ordered by the Physician.</p> <p>During an interview on 07/20/15 at 11:28 a.m., LPN #1 indicated she had not administered the loratadine-pseudoephedrine to Resident #F. LPN #1 indicated she had not taken the medication out of the Pyxis.</p> <p>During an observation of the Pyxis on 07/20/15 at 2:01 p.m., LPN #3 indicated the loratadine-pseudoephedrine was available in the Pyxis.</p> <p>A meal time schedule, received from the Dietary Manager, on 07/20/15 at 2:15 p.m., indicated the breakfast meal was served at 7 a.m.</p> <p>2. During an observation of the medication administration, on 07/20/15 at 8:40 a.m., LPN #2 prepared Resident #G's morning medication, which included, gabapentin (nerve pain medication) 600 mg, one tablet three times daily and Restasis (corneal degeneration) eye drop, one drop in both eyes two times daily.</p> | | | | |

| | | | |
|--|---|--|---|
| 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 07/21/2015 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>As LPN #2 placed the oral medications into the medication cup and the gabapentin fell from the package onto the medication cart. LPN #2 picked up the gabapentin and placed the medication into the trash container on the medication cart, then picked the gabapentin from the trash and placed the tablet in the Sharp's container. LPN #2 then indicated she would need to retrieve the gabapentin from the Pyxis.</p> <p>LPN #2 continued to prepare the rest of Resident #G's medication, then entered the resident's room and administered the oral medications without retrieving the gabapentin from the Pixy's.</p> <p>LPN #2 then administered two drops of Restatsis into each of the resident's eyes.</p> <p>During an interview after the medication was administered, LPN #2 indicated the resident received two drops of the Restatsis, LPN #2 then looked at the MAR and indicated the resident should have only received one drop of Restatsis in each eye. LPN #2 then signed the MAR as all medications given, including the gabapentin.</p> <p>Resident' #G's record was reviewed on 07/20/15 at 11 a.m., the resident's</p> | | | |

| | | | | | |
|--|--|---|---|----------------------|---|
| 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 07/21/2015 |
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>diagnoses included, but were not limited to, polyneuropathy, diabetes mellitus, and stroke.</p> <p>The Physician's Recapitulation Orders, dated 07/20/15, included medication orders for gabapentin 600 mg, one tablet three times a day at 9 a.m., 1 p.m., and 9 p.m. and Restasis Emulsion 0.05%, instill one drop in both eyes two times a day for corneal degeneration at 9 a.m. and 5 p.m.</p> <p>During an interview on 07/20/15 at 11:26 a.m., LPN #2 indicated Resident #G had not received the gabapentin and the medication had not been taken from the Pyxis. LPN #2 stated, "I forgot".</p> <p>During an observation of the Pyxis on 07/20/15 at 2:01 p.m., LPN #3 indicated the gabapentin was available in the Pyxis.</p> <p>This Federal Tag relates to Complaint IN00176024.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> | | | | |