

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155556	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2015
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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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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 27, 28, 29, 30, November 2, 3, &amp; 4, 2015.</p> <p>Facility number: 000505 Provider number: 155556 AIM number: 100266350</p> <p>Census bed type: SNF: 26 SNF/NF: 111 Total : 137</p> <p>Census payor type: Medicare: 19 Medicaid: 81 Other: 37 Total: 137</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 21662 on November 12, 2015.</p>	F 0000	<p>November 26, 2015 Kim Rhoades, Director Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Survey Event ID: ID VVNL11 Dear Ms Rhoades:</p> <p>Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during our recent Complaint Survey on November 5, 2015 at Miller's Merry Manor in Tipton. Hopefully, you will find that our remedies are both sufficient and thoroughly explained in providing you a clear picture of how we corrected these concerns. With this submission of these remedies, and the fact that we are requesting an IDR for our most serious deficiency due to additional information being provided which we were not permitted to submit during the survey process due to time constraints of the survey team, <b>we are requesting paper compliance.</b> If, after reviewing our plan of correction, you have any questions or require further information, please do not hesitate to contact me at your convenience at (765)675-8791. Respectfully submitted, Paula Juday, MSW, HFA Administrator</p>	
F 0250	483.15(g)(1)			

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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SS=G Bldg. 00	<p><b>PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b></p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to monitor the cursing and wandering behaviors of a resident causing other residents to voice concerns (Resident #49, #62, and #119) and to vocalize fear (Resident #34 and #69) for 1 of 1 residents reviewed for behaviors (Resident #133).</p> <p>Findings include:</p> <p>The record of Resident #133 was reviewed on 10/29/2015 at 11:07 a.m. Diagnoses included, but were not limited to, encephalopathy, mood disorder, and dementia without behavioral disturbance.</p> <p>A Physician's Order, dated 10/06/15, indicated Depakote Sprinkles (an anti-convulsant used as a mood stabilizer) 125 mg (milligrams) daily every noon.</p> <p>A Physician's Order, dated 10/09/15, indicated Depakote Sprinkles 125 mg every noon and every 6 p.m., for aggression and dementia.</p>	F 0250	<p><b>F-250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICES</b> It is the policy of Miller's Merry Manor to provide a systematic method for identification of specific behaviors that may impact the resident's quality of life or cause concern to the resident. To correct this deficiency: · For resident #133, the behavior of cursing was added to the behavior tracker under yelling. The resident's behavior of yelling out includes cursing. A behavior tracker for wandering was initiated for resident #133. All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected: · 100% audit of residents in the facility whom have the behavior of cursing and / or wandering to ensure that all residents who have these behaviors have behavior tracking in place. To prevent recurrence: · All staff will be in-serviced regarding the policy and procedure for: Behavior Assessment &amp; Management (1-A). To be completed on or before 11/20/15. · Social Services Director or designee will audit 3 residents for behaviors requiring behavior trackers at least daily (M-F) for</p>	11/30/2015			

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	<p>A Behavior Tracking Documentation Survey Report indicated the following behaviors were tracked for August and September 2015:</p> <p>"...Document Mood behavior #1: increased anxiety aeb [as evidenced by] yelling out, asking repetitive questions...Interventions: [1] Offer reassurance, support and tlc [tender loving care] [2] Redirect to another activity, offer beverage and/or snack, distract with conversation [3] Assure Res [resident] she is safe [4] Encourage Res [resident] to voice her concerns and address ASAP...."</p> <p>A social services progress note, dated 09/30/15, indicated "...Res [resident] has noted to be more irritable, yelling out...not easily redirectable. Resident was just yelling loudly at this writer [social services] cursing...Resident's seroquel was discontinued 9-2-15. Reviewed behavior tracking and behavior has been occurring nearly dly [daily] of yelling out. Appears to have increased anxiety aeb [as evidenced by] restless and yells out...Not able to redirect...."</p> <p>A Nursing Behavior Assessment, dated 9/30/15, indicated Resident #133 was "...found by social services at front entrance to facility yelling obscenities and screaming at visitors coming into</p>		<p>compliance. This will be implemented on or before 11/30/15. · The DON or Designee will monitor compliance using the QA tool titled "Social Services: Behavior Tracking Audit" daily (M-F) X30 days, then weekly X4weeks, then monthly thereafter. This QA tool will be started on or before 11/30/15.</p> <p>Attachments: <i>Policy &amp; Procedure: Behavior Assessment &amp; Management (1-A); QA Tool Audit: Social Services: Behavior Tracking Audits(1-B)</i>. IDR:Miller's Merry Manor of Tipton respectfully requests to informally dispute F250. We request F250 be completely deleted from the survey findings. We ask this due to the fact that the facility was not given the opportunity to provide further information regarding the resident identified as wandering, #133, and the facility does have other pertinent information to report. The facility completed an investigation into this matter and determined resident #133 does not wander into other resident rooms. Please see attachment IDR (A) dated 9/13/15 &amp; IDR (B) dated 11/13/15 that shows resident #133 is totally dependent for performing locomotion both on &amp; off of the unit. These attachments are #133's most recent MDS completed prior to and after this survey process. This shows that there has been no change in this level of assistance needed over the last</p>		

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	<p>building. Resident stated, 'I don't know where the h--- to go' and 'What the h--- is going on?' Resident has shown an increase in anxiety and nervousness since Seroquel was discontinued a few weeks ago in September...Behavior begins occurring in the afternoon around 3:00 p.m. and continues until resident goes to bed approximately at 8:00 p.m. At times there is an activity going on and the resident is taken to the activity but she will not stay there. She continues to ambulate through the hallways yelling and wandering around the facility...."</p> <p>A follow up note to the Nursing Behavior Assessment, dated 10/1/15, indicated when staff or other residents would try to talk to Resident #133 she would state "shut the h--- up" or "who gives a d---." This occurred all during the shift. Resident #133's response to interventions was to state, "...leave me the d--- alone."</p> <p>A follow up note to the Nursing Behavior Assessment, dated 10/1/15, indicated "...Resident yelling, 'help me' and 'where do I go now?' Also says 'oh well, who gives a d---?' Resident chews on nails until they bleed and cannot be still, constantly moving around. Yells during activities and is disruptive to others...." The note indicated the behavior occurred all shift and interventions were not</p>		<p>couple of months. Resident #133 requires assistance for locomotion throughout the facility. In regards to not tracking wandering, during the survey process, the Administrator and DON provided information indicating that resident #133 did not wander, as noted in the 2567. Resident #133 also did not have wandering observed by surveyors in the 2567, only reported in error by residents. During the survey process, several residents were interviewed regarding their concerns / fears. 3 residents (#49, #119, #62) were identified as expressing concerns about resident #133, and 2 residents (#34, #69) were identified as expressing fear of resident #133. These resident were asked in an interview if #133 specifically has ever wandered into their room. Residents #49 and #119 expressed concern with resident yelling out (which is being tracked), but deny that resident has ever wandered into their room, and in fact resident #119 stated that he at times invites resident #133 into his room. Resident #49 and resident #34, stated it was actually another resident about which they had concerns, not resident #133. Resident A, whom had already been addressed appropriately by the Social Service Director. Please see attachment IDR (c), a progress note showing where</p>		

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	<p>effective.</p> <p>A follow up note to the Nursing Behavior Assessment, dated 10/3/15, indicated "...continues to yell out in hall way, lounge, and dining room. Help me, who do you think you are when they answer she will state then go to h---...occurred all during first shift..."</p> <p>A Nursing Behavior Assessment IDT(interdisciplinary team) Evaluation, dated 10/5/15, indicated "...Resident's seroquel has been discontinued on 9-2-15 and yelling out/repetitive questions/anxiety has notably gotten worse since the medication was discontinued. Resident has been cursing more lately which is not a norm for her...Will update her physician and [psychiatrist]. Will see [psychiatrist] on next visit. continue with current behavior tracker, SSD [Social Service Director] will slightly adjust what we are monitoring, but otherwise continue as is...."</p> <p>A Psychiatry Progress Note and Treatment Summary, dated 10/9/15, indicated "...asked to check. Staff reports she's been more agitated/irritable with episodes of yelling out, 'help me, where do I go?' Yelled @ [at]/cursed nurse who simply greeted her. She is unable to stay</p>		<p>Resident A was transferred to a Dementia Unit on 10/28/15 to maintain all resident's highest practicable physical, mental and psychosocial well-being. Also attached is Resident A's level of assistance required for locomotion at time of discharge (supervision) Attachment IDR (D). Resident #62 is unidentifiable by the Resident Sample List provided during exit conference. No information about resident #62 was provided by during the survey or during the exit conference. For resident #69, information provided during the survey process showed that during his interview, he reported that resident #133 came into his room, but that his roommate (resident #119), invites her into roommate's portion of the room. Included in the IDR are statements from the 4 identified residents regarding their well being and lack of fear of resident #133 Attachment IDR (E). Furthermore, Resident #133 has a BIMS of 3. As noted within the 2567 resident is being monitored for yelling, is seen routinely by the Psychiatrist with medication management and has on-going follow up being completed by the Social Service Director for behavior management. The cursing exhibited by Resident #133 is noted at times when she is yelling out and would be covered under the behavior tracker for yelling out. Resident's</p>		

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	<p>focused in activities, is in and out of room[multiple] times as she can't sit still. [Psychiatrist] was called and adjusted some of her meds, started depakote...."</p> <p>Behavior tracking Documentation Survey Report indicated the following behaviors were monitored for October 2015: "...Document Mood behavior #1: increased anxiety aeb yelling out, asking repetitive questions...Interventions: [1] Offer reassurance, support and tlc [2] Redirect to another activity, offer beverage and/or snack, distract with conversation [3] Assure Res she is safe [4] Encourage Res to voice her concerns and address ASAP...."</p> <p>Behaviors of wandering and cursing were not monitored by the facility.</p> <p>During an observation on 10/28/2015 at 12:45 p.m., Resident #133 was observed cursing in the Meadows lounge area. She was also observed yelling out, "hey, hey" and "what are we going to do?" to people as they passed by the lounge.</p> <p>During an interview on 10/29/15 at 10:14 a.m., Resident #49 indicated Resident #133 had "...cussed [her] out a few times and told [her] where to go." Resident #49 indicated Resident #133 was constantly yelling up and down the hall. She</p>		<p>behavior of yelling out (including cursing) is related to her cognitive impairment due to the diagnosis of dementia. Therefore, adding cursing to behavior monitoring separate from yelling out, would be pointless as this will not change the plan of care in place. By monitoring "Yelling" this covers the true behavior no matter the verbiage used. In conclusion, please consider deleting F250 from our survey results completely or at the very least reduce the scope &amp; severity of the tag. We have submitted documentation, showing that no resident was actually fearful of the resident identified in the 2567 as resident #133, and that no resident sustained any psychosocial distress as a result of the behaviors of resident #133. While things are always going to happen that are out of our control, it is our job to handle them correctly once we are aware. We feel that we have handled the above situations correctly and have remained in compliance with the F250 regulation. Again, we were unable to provide this information during the survey process, due to time constraints for the survey team. Please fee free to call me at 765-675-8791. Thanks for your time and consideration in this matter. Paula Juday, MSW, LSW, HFA Administrator</p>				

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	<p>indicated Resident #133 yelled at her yesterday about her shoes when she was trying to help her. Resident #49 indicated Resident #133 wandered into other resident's rooms and tried to get in their beds, as well as yelled at other residents. Resident #49 indicated she felt the staff did not do anything about the cursing and wandering and indicated the staff stated that she (Resident #133) can't help herself.</p> <p>During an interview on 10/29/2015 at 11:30 a.m., Resident #34 indicated she was afraid of Resident #133 because she (Resident #34) had one leg and she could not get up by herself to get out of her room if needed. She indicated neither she nor her roommate could defend themselves if Resident #133 attempted to do something to either one of them. Resident #34 indicated Resident #133 came into her room yesterday. When Resident #34 asked Resident #133 what she was doing in her room, Resident #133 told Resident #34 to "shut up." Resident #34 indicated Resident #133 got into her bathroom one day and Resident #34 had to yell to get the staff to get her out of her room. She indicated Resident #133 came into her room everyday and she had to have her taken out.</p> <p>During an interview on 10/29/2015 at</p>				

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	<p>11:43 a.m., Resident #69 indicated he was afraid of Resident #133. Resident #69 indicated Resident #133 cursed and yelled in the facility and was intrusive during activities. Resident #69 indicated Resident #133 last yelled at him approximately one week ago.</p> <p>During an interview on 10/29/2015 at 12:02 p.m., Resident #62 indicated Resident #133 wandered into his room at times and seemed very confused.</p> <p>During an interview on 10/30/2015 at 2:37 p.m., Resident #119 indicated Resident #133 shouted on the unit randomly and disrupted meal time. Resident #119 indicated staff did not always intervene.</p> <p>During an interview on 10/29/2015 at 11:48 a.m., LPN #10 indicated Resident #133 yelled out a lot. She indicated Resident #133 cursed, but it was usually directed at another resident who had passed away. She thought he was her husband. They used to sit at the same table and spar back and forth. It would bother those around them, so staff would separate them. LPN #10 indicated Resident #133 yelled towards a group of residents one other time to her knowledge. LPN #10 indicated the residents were talking and Resident #133</p>			

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	<p>yelled something like, "shut the h--- up!" LPN #10 indicated staff attempted to redirect behaviors. She also indicated Resident #133 wandered to the doorway of other residents' rooms and the downstairs area of the facility.</p> <p>During an interview on 10/29/2015 at 11:48 a.m., CNA #12 indicated Resident #133 sometimes argued with some of the residents and yelled at them. CNA #12 indicated the arguments usually occurred because Resident #133 did not want other residents to sit by her. CNA #12 indicated she heard one resident complain about Resident #133.</p> <p>During an interview on 10/29/2015 at 12:05 p.m., the Activities Director indicated Resident #133 typically yelled out towards the end of activities, so she was the first resident to be taken back to her room. She indicated she saw Resident #133 in the facility, outside of activities, and observed her cursing in general. She indicated she had not been concerned about this because it was just a part of who Resident #133 was.</p> <p>On 10/29/2015 at 1:40 p.m., the Administrator and Director of Nursing were informed of concerns related to cursing and wandering behaviors of Resident #133. They indicated they had</p>			

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F 0312 SS=D	<p>no awareness Resident #133 was wandering into resident rooms.</p> <p>During an interview on 11/05/2015 at 11:07 a.m., the Social Service Director (SSD) indicated she did not feel cursing was a behavior that required monitoring for Resident #133 because it was not causing her any distress. It was a part of who she was as a person. The SSD indicated she felt Resident #133 was not aware of what she was doing due to her dementia diagnosis. She indicated wandering could be put in a careplan, but was not something that was really trackable.</p> <p>A current policy titled Psychotropic Drug Use Policy, dated 06/01/2011, provided by the Director of Nursing on 11/5/15 at 10:56 a.m., indicated "...Anticonvulsant... used for managing behavior, stabilizing mood, or treating psychiatric disorders...target behaviors must be clearly identified and monitored. Episodes will be documented in the clinical record as they occur along with the results of the interventions used to reduce the behavior or symptom...."</p> <p>3.1-34(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT</p>			

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Bldg. 00	<p><b>RESIDENTS</b></p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to provide nail care and facial hair care for a dependent resident for 1 of 3 residents reviewed for Activities of Daily Living (ADL). (Resident #136)</p> <p>Findings include:</p> <p>During an observation on 10/30/15 at 2:17 p.m., Resident #136's right hand was contracted and his left hand was formed into a closed fist. The nails were long and were observed to have debris under the thumb on the right hand. The resident was also observed to have razor stubble on his chin, cheeks and around his mouth.</p> <p>A record review was completed for Resident #136 on 11/04/15 at 9:26 a.m. Diagnoses included, but were not limited to, cerebral palsy, anxiety and neurogenic bladder.</p> <p>The ADL documentation in the computer indicated to shave daily FYI (for your information). The nail care was documented with the bathing</p>	F 0312	<p><b>F-312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS.</b> It is the standard of Miller's Merry Manor to provide ADL care to dependent residents in order to maintain good nutrition, grooming, and personal and oral hygiene. To correct this deficiency:</p> <p>Resident #136 was immediately provided with ADL care, including nail care, shaving, and shower.</p> <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected:</p> <ul style="list-style-type: none"> <li>· 100% audit of dependent residents for nail care and shaving was completed on 11/4/2015 with all residents who needed nail care or shaving being done on 11/4/2015. To be completed on or before 11/4/15.</li> </ul> <p>To prevent recurrence:</p> <ul style="list-style-type: none"> <li>· All nursing and CNA staff will be in-serviced regarding ADL care policy and procedures, including nail care (2-A) and shaving (2-B). To be completed on 11/20/15.</li> <li>· DON or designee will make at least 3 spot checks daily (M-F) to ensure that dependent residents are receiving daily ADL care as indicated in their Plan of Care and CNA assignment sheets, including but not</li> </ul>	11/30/2015			

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F 0315 SS=D Bldg. 00	<p>information. The documentation indicated the resident had received a full sponge bath (including nail and oral care) on 10/8/15, 10/12/15, 10/15/15, 10/19/15, 10/26/15 and 10/29/15.</p> <p>The Care Plan dated 2/14/15 indicated "...extensive total assist with ADL due to memory deficit, weakness. : Interventions: staff to provide complete bed bath on shower days due to severe contractures and pain of movement. ADL-nail care on shower/bath day... Shave daily...."</p> <p>On 11/04/2015 at 2:08 p.m., the DON (Director of Nursing) indicated a new CNA had not documented ADL care.</p> <p>3.1-38(a)(3)(D) 3.1-38(a)(3)(E)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to</p>		<p>limited to: nail care and shaving. This will be implemented on or before 11/30/15.</p> <p>The DON or Designee will monitor compliance using the QA tool titled "ADL Care Audit" daily (M-F) X30 days, then weekly X4weeks, then monthly thereafter. This QA tool will be started on or before 11/30/15.</p> <p>Attachments: <i>Standards of Care: Quality of Care: Nail Care (2-A); QA Tool "ADL Care Audit" (2-C)</i></p>				

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	<p>restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper Foley catheter bag placement to prevent a urinary tract infection for 1 of 1 residents reviewed for catheter care. (Resident #37)</p> <p>Findings include:</p> <p>On 11/02/15 at 1:02 p.m., the record review for Resident #37 was completed. Diagnoses included, but were not limited to, dementia, history of sepsis, urinary tract infections and pressure wounds.</p> <p>The Physician's Orders indicated the resident was on Cipro (an antibiotic) 500 milligrams 1 tablet by mouth twice daily for a urinary tract infection from 10/27/15 through 11/1/15.</p> <p>During an observation on 10/30/15 at 2:35 p.m., Resident #37 was observed to have her Foley catheter tubing underneath of her left leg. The urine was observed pooling in the tubing near the resident's bladder, amber in color and had sediment observed in it. The Foley catheter drainage bag was on the floor with the drain valve tube not secure on the drainage bag was on the floor. The plastic sleeve that held the drain valve</p>	F 0315	<p><b>F-315 NO CATHETER, PREVENT UTI, RESTORE BLADDER</b> It is the policy of Miller's Merry Manor to maintain a closed drainage system for all anchored catheters and not break the closed system unnecessarily. Included in this policy is the catheter care and maintenance, including placement of catheter tubing on the side of the bed, and not touching the floor. To correct this deficiency: Resident #37's catheter was immediately replaced with a new catheter.</p> <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected:</p> <ul style="list-style-type: none"> <li>· 100% audit of with catheters was completed on 11/4/2015 to ensure all catheters were maintaining a closed system and were placed according to policy. To be completed on or before 11/4/15.</li> <li>To prevent recurrence: <ul style="list-style-type: none"> <li>· All nursing and CNA staff will be in-serviced regarding catheter care. To be completed on 11/20/15.</li> <li>· DON or designee will make at least 1 spot checks daily (M-F) to ensure that residents with catheters are maintaining a closed system and placement is correct for the catheter. This will be implemented on or before 11/30/15.</li> <li>· The DON or Designee will monitor compliance using the QA tool titled "Catheter Care Audit"</li> </ul> </li> </ul>	11/30/2015
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F 0323 SS=D Bldg. 00	<p>tube onto the drainage bag was ripped.</p> <p>During an interview and observation on 10/30/15 at 2:37 p.m., CNA #9 indicated the Foley catheter drainage tubing was not supposed to be underneath of the leg of the resident. CNA #9 took the Foley catheter drainage bag and held it above bladder level while she was moving the tubing from underneath of the resident's leg with ungloved hands. CNA #9 took the drainage valve tube and attempted to insert it into the plastic drain valve sleeve. The drain valve tube would not secure into the sleeve of the Foley catheter drainage bag. CNA# 9 indicated at that time she needed to get some gloves. She donned a pair of gloves with unwashed hands and placed the catheter drainage bag inside a dignity bag then attached the dignity bag to the side rail of the resident's bed.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the</p>	F 0323	<p>daily (M-F) X30 days, then weekly X4weeks, then monthly thereafter. This QA tool will be started on or before 11/30/15.</p> <p>Attachments: <i>Nursing Policy &amp; Procedure Foley Catheter Care &amp; Maintenance (3-A); QA Tool "Catheter Care Audit" (3-B)</i></p>	11/30/2015	

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	<p>facility failed to ensure 1 of 6 medication carts and 1 of 6 treatment carts were kept locked.</p> <p>Findings include:</p> <p>1. On 10/28/15 at 3:49 p.m., the nurse's medication cart on the Aviary unit (a locked dementia care unit) was observed to be unlocked. LPN #7 came walking briskly out of a resident's room halfway down the hallway and darted between two people standing by the nurse's station. LPN #7 locked the medication cart and walked back down to the resident's room.</p> <p>During an interview on 10/28/15 at 4:05 p.m., LPN #7 indicated she should have locked the medication cart when she left it, "...especially up here."</p> <p>A current policy titled "Medication Administration Procedure," dated 10/4/2012, provided by the Director of Nursing on 10/29/15 at 3:55 p.m., indicated "...13. Lock the medication cart before leaving it ...."</p> <p>2. During the initial tour, on 10/27/2015 at 10:28 a.m., the nurse's treatment cart on the North Terrace unit was observed to be unlocked. No staff were observed in the hallway. RN #8 came out of a</p>		<p><b>HAZARDS</b> It is the standard of Miller's Merry Manor to ensure that the environment is safe for residents, including locking medication and treatment carts when not in use. To correct this deficiency: Staff members LPN#7 and RN#8 were immediately re-educated about the process of locking their carts during medication / treatment administration. All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected: · Both LPN#7 and RN#8 immediately locked their carts for safety. To prevent recurrence: · All nursing staff will be in-serviced regarding medication administration procedure, and specifically locking medication / treatment carts. To be completed on 11/20/15. · DON or designee will make at least 3 spot checks daily (M-F) of medication and / or treatment carts to ensure that they are locked when not in use. This will be implemented on or before 11/30/15. · The DON or Designee will monitor compliance using the QA tool titled "Medication / Treatment Cart Audit" daily (M-F) X30 days, then weekly X4weeks, then monthly thereafter. This QA tool will be started on or before 11/30/15. Attachments: <i>Nursing Policy &amp; Procedure Medication Administration Procedure (4-A); QA Tool Audit: Medication Administration: Medication and</i></p>		

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F 0325 SS=D Bldg. 00	<p>resident's room at 10:33 a.m., walked over to the treatment cart and locked it.</p> <p>During an interview on 11/05/15 at 10:37 a.m., the Director of Nursing indicated there was not a separate policy regarding treatment carts, but they should be locked when not in use.</p> <p>3.1-45(a)(1)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review the facility failed to have a weight loss intervention implemented for 1 of 3 residents reviewed for nutrition. (Resident #173)</p> <p>Findings include:</p> <p>On 11/04/15 at 10:06 a.m., the record review for Resident # 173 was completed. Diagnoses included, but were not limited to, Alzheimer's disease, and a</p>	F 0325	<p><i>Treatment Carts (4-B).</i></p> <p><b>F-325MAINTAIN NUTRITION STATUS</b> It is the policy of Miller's Merry Manor to provide nourishment to all residents who need additional nutrients and calories as deemed necessary by the interdisciplinary team and the physician.. To correct this deficiency: Resident #173 was immediately provided with super cereal with his breakfast. All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected: · All menus will</p>	11/30/2015			

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	<p>history of a fractured femur.</p> <p>The resident's weights were as follows: 8/16/15- 165.2 8/17/15- 165.2 8/20/15- 165.2 9/1/15- 150.6 9/6- 144.6 9/13- 143.6 10/4- 141.0 10/12- 139.2 10/14- 139.7 10/21- 139 10/29-139.0 11/1- 141.8</p> <p>The resident physician's orders for nutrition supplements indicated: 8/12/15- Regular Diet 8/13/15-Multivitamin 10/14/15 -2 CAL HN (a nutritional supplement) four times a day.</p> <p>The Registered Dietician (RD) assessment dated 8/13/15, indicated the resident was at risk for malnutrition. The resident's usual weight was 155-165.</p> <p>The Care Plan, dated 8/17/15 with revision date of 9/11/15, indicated: Nutritional Risk related to weight loss related to decreased intake and cognitive status. Interventions: Serve diet as ordered : Regular diet, snacks available</p>		<p>be checked using a 2 step procedure for "extras". The 2 step procedure will include the cook preparing the plate and the server serving the food. Both staff members will check for any "extras" added to the meal ticket and will ensure that those are delivered to the resident. To prevent recurrence: · All staff will be in-serviced regarding menu "extras" including, but not limited to Super Cereal., To be completed on 11/20/15. · Dietary Manager or designee will make at least 3 spot checks daily (M-F) of residents with "extras" on their menu to ensure residents are receiving those "extra" items. This will be implemented on or before 11/30/15. · The Dietary Manager or Designee will monitor compliance using the QA tool titled "Dietary: "Extras" Audit" daily (M-F) X30 days, then weekly X4weeks, then monthly thereafter. This QA tool will be started on or before 11/30/15. Attachments: <i>Policy &amp; Procedure: Nutritional Oral Supplements(5-A); QA Tool Audit: Dietary Extras(5-B)</i>. IDR: Miller's Merry Manor of Tipton respectfully requests to informally dispute F325. We request F325 be completely deleted from the survey findings due to inaccurate information included in the 2567 deficiency finding. According to the 2567 (page 1), the survey dates were October 27, 28, 29, 30, November 2, 3, &amp; 4. The</p>				

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	<p>to resident between meals upon request. Offer replacement for foods uneaten or consumes less 50%. Resident will select own menus. Serve 4 oz super cereal at breakfast. serve 1 ounce additional protein at breakfast.</p> <p>The RD assessment dated 9/20/15 indicated the resident's weight was 143.6 and had a weight loss of 21.6 pounds or 13.1 % in 30 days. The documentation from the RD indicated she added 1 ounce of extra protein and super cereal to the breakfast meal due to weight loss.</p> <p>The last 30 days for meal consumption indicated the resident took less than 51% on 10/8, 10/10, 10/16, 10/17, 10/20 x 2 meals, 10/21, 10/22, 10/31, 11/1. The documentation indicated the resident had declined the morning meal on 11/4/15.</p> <p>During an observation of the breakfast meal on 11/04/15 at 8:20 a.m., Resident #137's meal ticket indicated, "... 'extras' Super Cereal/ Protein 1/2 cup 1 oz'.....". The resident had ordered a sausage patty, scrambled eggs, buttered white toast with jelly, juice and milk. He ate all of the toast and eggs, but did not consume the sausage. There was no bowl of Super Cereal observed on table.</p> <p>During an interview on 11/04/15 at 8:25</p>		<p>deficiency F325 on the 2567 (page 15) indicates that on 11/5/15, Resident #137's meal ticket indicated "extras" Super Cereal / Protein ½ cup 1 oz...</p> <p>The 2567 continue to read, during an interview on 11/5/15 at 8:25am, LPN #11 indicated there was no super cereal provided. Since this is outside of the dates indicated above for the survey period, this information should be removed from the 2567. Also, according to this deficiency, the findings are that the facility failed to have a weight loss intervention implemented for resident #173. However, the following physician's orders were actually implemented and part of the care plan for resident #173 as indicated in the 2567: Multivitamin and 2Cal HN 4 times a day.</p> <p>Other interventions on residents care plan (2567 page 14) include: snacks available between meals, replacement for foods when consuming less than 50% of meals, and resident selecting his own menus. Based on this information, there are weight loss interventions implemented for resident #173. In conclusion, please consider deleting F325 from our survey results completely due to incorrect information being included in the 2567. Please fee free to call me at 765-675-8791. Thanks for your time and consideration in this matter. Paula Juday, MSW, LSW, HFA Administrator</p>		

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F 0371 SS=F Bldg. 00	<p>a.m., LPN #11 indicated there was no super cereal provided.</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p> <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 ensure thermometer probes were sanitized prior to the temperature-taking procedure, the staff handled clean dishware with clean hands, and food was served after following temperature-taking procedures in 1 of 1 kitchens. This deficient practice had the potential to affect 73 of 73 residents receiving food from the kitchen.</p> <p>Findings include:  On 10/27/15 at 11:51 a.m., Cook #1 picked up 12 thermometer probes from a round black container sitting by the steam table, then placed a probe through the aluminum foil covering on top of each food item on the steam table without</p>	F 0371	<p><b>F-371 FOOD PROCURE, STORE/PREPARE/ SERVE – SANITARY</b> It is the policy of Miller’s Merry Manor that all food be prepared and served in a clean, sanitary, and safe manner. To correct this deficiency:</p> <ul style="list-style-type: none"> <li>· All thermometer probes were immediately sanitized by dietary staff. Dietary staff were immediately educated regarding the policy and procedure for food preparation, handling, and service.</li> </ul> <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected:</p> <ul style="list-style-type: none"> <li>· All dietary staff were immediately educated regarding the policy and procedure for food preparation, handling, and service.</li> </ul>	11/30/2015	

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	<p>sanitizing them.</p> <p>On 10/27/15 at 12:13 p.m., Food Server #2 started serving lunch in the kitchen.</p> <p>On 10/27/15 at 12:18 p.m., Cook #1 started serving lunch in the kitchen. She picked up four bowls and her left thumb was inside the lip area (top of the bowl) while she carried the bowls to the serving area. She dipped Cauliflower Soup into the bowls, then placed them onto the large black serving trays for the dining room server staff to deliver to the residents.</p> <p>On 10/27/18 at 12:30 p.m., Food Server #2 picked up a bowl and her right thumb was inside the lip area of the bowl while she carried it to the serving area. She dipped Cauliflower Soup into the bowl, then placed it onto the large black serving tray for the dining room server staff to deliver to a resident.</p> <p>On 10/27/15 at 12:39 p.m., Cook #1 pulled a pan of Burrito Casserole out of the oven, then placed it on the steam table. Food Server #2 cut a piece of the casserole, placed it on a plate, then finished preparing the plate. She placed the plate on the large black serving tray, then a dining room server picked it up. The ADM (Assistant Dietary Manager)</p>		<p>No residents were negatively affected by this practice.</p> <p>To prevent recurrence:</p> <ul style="list-style-type: none"> <li>· All dietary staff will be in-serviced regarding the policy and procedure for food preparation, handling, and service. To be completed on or before 11/20/15.</li> <li>· Dietary Manager or designee will audit at least 1 meal daily (M-F) for compliance with sanitizing thermometer probes and handling dishware according to policy. This will be implemented on or before 11/30/15.</li> <li>· The Dietary Manager or Designee will monitor compliance using the QA tool titled "Dietary: Sanitation Audit" daily (M-F) X30 days, then weekly X4weeks, then monthly thereafter. This QA tool will be started on or before 11/30/15.</li> </ul> <p>Attachments: <i>Policy &amp; Procedure: Food Preparation, Food Handling, and Service (6-A); QA Tool Audit: Dietary Sanitation Audits(6-B).</i></p> <p>IDR: Miller's Merry Manor of Tipton respectfully requests to informally dispute F371. We request F371 be completely deleted from the survey findings due to inaccurate information included in the F371</p>		

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	<p>was notified the temperature of the Burrito Casserole was not taken prior to the piece of Casserole being plated to be served to a resident. The ADM stopped the dining room server prior to her serving the piece of Burrito Casserole. The ADM indicated at that time the dietary staff were not to serve food without it being temped first.</p> <p>On 10/27/15 at 12:43 p.m., Cook #1 picked up a thermometer probe from the black round container sitting by the steam table, then placed it into the Burrito Casserole without sanitizing it.</p> <p>On 10/27/15 at 12:47 p.m., Cook #1 removed mashed potatoes from the oven, then placed them on the steam table. She picked up a thermometer probe from the round black container by the steam table, then placed it into the potatoes without sanitizing it.</p> <p>On 10/27/15 at 1:00 p.m., Cook #1 picked up two thermometer probes from the round black container by the steam table, then placed a thermometer probe into each of the grilled cheese sandwiches without sanitizing them.</p> <p>On 10/27/15 at 1:04 p.m., the ADM picked up two thermometer probes off the steel counter, then placed a</p>		<p>deficiency finding. Furthermore, we ask this due to the fact that the facility was not given the opportunity to provide further information regarding the staff member identified as the ADM (Administrator), and the facility does have other pertinent information to report.</p> <p>According to the 2567, the ADM (Administrator) was in the kitchen during the meal service on 10/27/15, she was notified the temperature of the Burrito Casserole was not taken prior to the piece of Casserole being plated to be served to a resident. The ADM stopped the dining room server and indicated that the dietary staff were not to serve food without temping it first. The 2567 continues to read that on 10/27/15 at 1:04 PM the ADM picked up two thermometers probes off the steel counter, then placed a thermometer</p>		

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	<p>thermometer probe into each of the grilled cheese sandwiches without sanitizing them.</p> <p>On 10/27/15 at 1:14 p.m., the ADM indicated the dietary staff and herself should have sanitized the thermometer probes with a probe wipe prior to taking the temperature of the foods. Cook #1 indicated she did not sanitize the thermometer probes prior to checking food temperatures. The ADM indicated the dietary staff serving the food should have picked up the bowls without their thumbs touching the lips of the bowls.</p> <p>A current policy titled " Food Preparation, Food Handling, and Service " dated 10/6/15, provided by the ADM on 10/27/15 at 2:59 p.m., indicated " ... 2. Procedure:... A ... IV. Sanitary handling of utensils and tableware-keeping hands off tines of forks, blades of knives, and bowls of spoons; not touching rims of glassware, eating surfaces of plates bowls and cups ... C ... III. Temperatures are checked with sanitized thermometers ... V. All meats are to be heated throughout to a minimum temperature of 145 [circle for degree] F [Fahrenheit] for beef roasts for a minimum of 4 minutes; for ground beef, pork, ham, sausage, bacon for a minimum temperature of 155 [circle for</p>		<p>probe into each of the grilled cheese sandwiches without sanitizing them.</p> <p>The 2567 continues to read that on 10/27/15, at 1:14p.m., the ADM indicated the dietary staff and herself should have sanitized the thermometer probes with a probe wipe prior to taking the temperature of the foods. The ADM indicated that the dietary staff serving food should have picked up the bowls without their thumbs touching the lips of the bowls. The 2567 continues to read that on 10/27/15, the ADM provided a policy titled "Food Preparation, Food Handling, and Service.</p> <p>At no time during the survey process was the Administrator present in the kitchen. The Administrator was not present during the meal service on 10/27/15. Furthermore, the Administrator did not use thermometer probes to check food temperatures on 10/27/15, and she did not</p>	

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	degree] F for 15 seconds ... The internal temperature is checked with a thermometer .... "  3.1-21(i)(3)		talk to any of the survey team about staff using probes or picking up bowls on 10/27/15. Lastly, the Administrator did not provide a policy titled "Food Preparation, Food Handling, and Service. This information included in the 2567 is in error.  In conclusion, please consider deleting F371 from our survey results completely due to incorrect information being included in the 2567. Again, we were unable to provide this information during the survey process, due to time constraints for the survey team. Please fee free to call me at 765-675-8791. Thanks for your time and consideration in this matter.  Paula Juday, MSW, LSW, HFA		

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F 0431 SS=E Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; 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 observation, interview and record review, the facility failed to properly</p>	F 0431	<p>Administrator</p> <p><b>F-431 DRUG RECORDS, LABEL</b> It is the policy of Miller's Merry Manor that all medications be labeled,</p>	11/30/2015	

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	<p>label medications after an order change for 2 of 10 resident's medication labels reviewed for direction change labels (Resident #42 and #58), failed to ensure open dates were on medications for 1 of 6 carts and 1 of 4 medication storage rooms reviewed for proper medication storage (Resident #78 and #101), failed to ensure a medication cart and a treatment cart were secured, and failed to ensure a discontinued medication was appropriately destroyed for 1 of 4 medication storage rooms. (Resident #118)</p> <p>Findings include:</p> <p>1. During an observation on 10/28/15 at 11:07 a.m., LPN #3 prepared medications for Resident #42. The nurse placed the medications into a plastic cup, which included Hydro (Hydrocodone) /APAP (Acetyl-Paraminophenol) (a narcotic pain medication) 5/325 mg (milligrams) one tablet. During this observation, the medication card for the medication provided from the pharmacy contained the following directions: Hydro/APAP 5/325 mg take one tablet by mouth every six hours as needed for pain. The dispensed date on the medication card was 10/27/15.</p> <p>During reconciliation of the current</p>		<p>stored, and disposed of according to regulations. To correct this deficiency:</p> <ul style="list-style-type: none"> <li>Change of order labels were immediately attached to the medications that had medication change orders; the medications lacking opened dates along with the discontinued medication were properly disposed of; LPN #7 and RN#8 immediately locked their carts and were provided with education regarding the Medication Administration Policy (7-A).</li> </ul> <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected:</p> <ul style="list-style-type: none"> <li>100% audit of all medication carts and medication rooms to ensure that all medications were labeled according to regulations, that all opened medications contained an open date, and that all medications that were expired or discontinued were discarded according to policy. LPN#7 and RN#8 immediately locked their medication cart and treatment cart, respectively.</li> </ul> <p>To prevent recurrence:</p> <ul style="list-style-type: none"> <li>All nursing staff will be in-serviced regarding the policy and procedure for medication labels including change orders and open dates, medication disposal, and medication administration including locking treatment and medication</li> </ul>	
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	<p>physician orders for October 2015, the resident had an order indicating 6/1/15- -Hydrocodone-Acetaminophen Tablet 5-325 mg give one tablet by mouth every six hours for pain. The medication card lacked a medication direction label change sticker to alert the nurses the order had been changed.</p> <p>During an interview on 10/28/15 at 11:10 a.m., LPN #3 indicated she would have to call the pharmacy to ask why the resident's label on this medication card had not been changed, since the new order was written on 6/1/15.</p> <p>2. During an observation on 10/28/15 at 11:53 a.m., LPN #3 turned the dial on the Novolog insulin flexpen (a medication used to lower a resident's blood sugar) to 12 units for Resident #58. During this observation, the label on the plastic bag provided from the pharmacy contained the following directions: Novolog 12 units subq (subcutaneously) (given in the fat tissue) daily with breakfast and lunch. Inject 14 units subq with supper. The dispensed date on the medication was 10/9/15.</p> <p>During reconciliation of the current physician orders for October 2015, the resident had an order indicating 6/30/15-Novolog solution 100 unit/ml</p>		<p>carts.. To be completed on or before 11/20/15.</p> <ul style="list-style-type: none"> <li>DON or designee will audit at least 1 medication cart and 1 medication room daily (M-F) for compliance with medication labeling including change order labels and open date, discontinued medication disposal, and locking of treatment and / or medication carts. This will be implemented on or before 11/30/15.</li> <li>The DON or Designee will monitor compliance using the QA tool titled "Medication Label / Disposal Audit" daily (M-F) X30 days, then weekly X4weeks, then monthly thereafter. This QA tool will be started on or before 11/30/15.</li> </ul> <p>Attachments: <i>Policy &amp; Procedure: Medication Labels(7-A); Policy &amp; Procedure: Storage of Medications (7-B); Policy &amp; Procedure: Medication Administration (7-C) QA Tool Audit: Medication Label, Disposal Audits(7-D).</i></p>	

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	<p>(milliliters) Inject 12 units subcutaneously two times a day for IDDM (Insulin Dependent Diabetes Mellitus). The medication card lacked a medication change direction label sticker to alert the nurses the order had been changed.</p> <p>During an interview on 10/28/15 at 11:56 a.m., LPN #3 indicated the resident had been receiving his insulin at 7 a.m. and 11 a.m., for awhile now and she would have to call the pharmacy and check on that order since it had started on 6/30/15. She indicated we always follow the orders on the Medication Administration Record not the medication labels.</p> <p>During an interview on 10/29/15 at 4:06 p.m., the Director of Nursing indicated medications that have had the orders changed should have a change of order sticker placed on the label until Pharmacy could send the medication with the updated labels.</p> <p>3. During an observation of the medication storage room on the Terrace area on 10/29/15 at 11:02 a.m., Resident #78's Mycophenolat Suspension (medication used to prevent transplant patients body's from attacking and rejecting a transplanted organ) 200 mg/ml bottle was observed in the medication</p>				

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	<p>refrigerator with no open date on the bottle. The medication was dispensed on 10/19/15. RN #4 indicated at that time the medication bottle should have had an open date.</p> <p>4. During an observation of the Vineyard medication cart on 10/29/15 at 10:10 a.m., Resident #101's Nitrostat Sublingual (a medication used to treat chest pain) 0.4 mg bottle was observed open in the cart with no open date on the bottle. The medication was dispensed on 6/11/15. LPN #5 indicated at that time the medication bottle should have had an open date placed on the bottle when it was opened, so the staff would know when the medication was expired.</p> <p>5. During an observation of the medication storage room on the Aviary area on 10/29/15 at 10:50 a.m., Resident #118's intravenous Cefoxitin one gram dose (an antibiotic medication) was observed in the medication refrigerator with a dispensed date of 9/21/15 and an expiration date of 9/27/15. LPN #6 indicated at that time this medication was an extra dose of medication and someone should have called pharmacy when the medication was finished and asked what pharmacy wanted staff to do with the extra dose.</p>			

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	<p>6. On 10/28/15 at 3:49 p.m., the nurse's medication cart on the Aviary unit (a locked dementia care unit) was observed to be unlocked. LPN #7 came walking briskly out of a resident's room halfway down the hallway and darted between two people standing by the nurse's station. LPN #7 locked the medication cart and walked back down to the resident's room.</p> <p>During an interview on 10/28/15 at 4:05 p.m., LPN #7 indicated she should have locked the medication cart when she left it, "...especially up here."</p> <p>A current policy titled "Medication Administration Procedure," dated 10/4/2012, provided by the Director of Nursing on 10/29/15 at 3:55 p.m., indicated "...13. Lock the medication cart before leaving it ...."</p> <p>7. During the initial tour, on 10/27/2015 at 10:28 a.m., the nurse's treatment cart on the North Terrace unit was observed to be unlocked. No staff were observed in the hallway. RN #8 came out of a resident's room at 10:33 a.m., walked over to the treatment cart and locked it.</p> <p>During an interview on 11/05/15 at 10:37 a.m., the Director of Nursing indicated there was not a separate policy regarding</p>			

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F 0441 SS=E Bldg. 00	<p>treatment carts, but they should be locked when not in use.</p> <p>3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(m) 3.1-25(o)</p> <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.</p>			

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	<p>(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 perform proper hand hygiene and glucometer sanitization to prevent cross contamination during blood glucose testing for 2 of 2 residents observed for blood glucose testing (Residents #143 and #58) and failed to perform proper hand hygiene to prevent cross contamination during medication administrations for 2 of 10 residents observed for medication administration. (Resident #143 and #58)</p> <p>Findings include:</p> <p>1. LPN #3 was observed performing a blood glucose test and administering insulin to Resident #143.</p> <p>a. On 10/28/15 at 11:36 a.m., LPN #3 was observed retrieving a cardboard box with glucometer supplies from the medication cart on the Garden unit. LPN #3 entered Resident #143's room with the cardboard box of glucometer supplies. She laid the glucometer and supply box</p>	F 0441	<p><b>F-441 INFECTION CONTROL</b> It is the practice of Miller's Merry Manor to investigate, control, and prevent infections in the facility. To correct this deficiency:</p> <ul style="list-style-type: none"> <li>LPN#3 was immediately educated regarding Medication Administration (8-A), Cleaning of a Glucometer (8-B), and the use of medical gloves (8-C). Neither resident was affected by this deficient practice.</li> </ul> <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected:</p> <ul style="list-style-type: none"> <li>LPN#3 was immediately educated regarding Medication Administration (8-A), Cleaning of a Glucometer (8-B), and the use of medical gloves (8-C).</li> </ul> <p>To prevent recurrence:</p> <ul style="list-style-type: none"> <li>All nursing staff will be in-serviced regarding the policy and procedure for: Medication Administration (8-A), Cleaning of a Glucometer (8-B), and the use of medical gloves (8-C). To be completed on or before 11/20/15.</li> </ul>	11/30/2015			

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	<p>on the resident's over the bed table without a barrier under them. She donned clean gloves without performing hand hygiene. She obtained the resident's blood sugar, washed her hands, collected the supplies, then exited the resident's room. She placed a disinfectant wipe around the glucometer, then laid the glucometer down on top of the medication cart without a barrier under it, then set the timer for 5 minutes. When the timer rang, LPN #3 removed the disinfectant wipe off the glucometer and placed it back into the cardboard box while it was visibly wet, then placed the supply box back into the medication cart.</p> <p>b. On 10/28/15 at 11:42 a.m., LPN #3 prepared Resident #143's Novolog insulin flexpen to administer 4 units, entered the resident's room, donned clean gloves without performing hand hygiene, then administered the insulin to the resident without performing hand hygiene prior to preparing or administering the insulin.</p> <p>2. LPN #3 was observed performing a blood glucose test and administering insulin to Resident #58.</p> <p>a. On 10/28/15 at 11:48 a.m., LPN #3 was observed retrieving a cardboard box with glucometer supplies from the</p>		<ul style="list-style-type: none"> <li>· DON or designee will audit at least 1 medication pass (including glucometer cleaning, handwashing, and glove usage) daily (M-F) for compliance with infection control. This will be implemented on or before 11/30/15.</li> <li>· The DON or Designee will monitor compliance using the QA tool titled "Infection Control Audit" daily (M-F) X30 days, then weekly X4weeks, then monthly thereafter. This QA tool will be started on or before 11/30/15.</li> </ul> <p>Attachments: <i>Policy &amp; Procedure: Medication Administration (8-A); Policy &amp; Procedure: Cleaning of a Glucometer ( 8-B); Policy &amp; Procedure: Use of Medical Gloves (8-C); QA Tool Audit: Infection Control Audits(8-D).</i></p>	

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	<p>medication cart on the Garden unit. LPN #3 entered Resident #58's room with the cardboard box of glucometer supplies. She laid the glucometer and the supply box of glucometer supplies on the resident's over the bed table without a barrier underneath them. She donned clean gloves without performing hand hygiene. She obtained the resident's blood sugar, washed her hands, collected the supplies, then placed the glucometer back into the cardboard supply box. LPN #3 exited the resident's room and placed the glucometer supply box back into the medication cart without disinfecting the glucometer.</p> <p>b. On 10/28/15 at 11:53 a.m., LPN #3 prepared Resident #58's Novolog insulin flexpen to administer 12 units, entered the resident's room, donned clean gloves without performing hand hygiene, then administered the insulin to the resident without performing hand hygiene prior to preparing or administering the insulin.</p> <p>The disinfectant wipe label indicated "...thoroughly wet pre-cleaned, hard, non-porous surface with a wipe, keep wet for 2 minutes (5 minutes if fungus is suspected) and allow to air dry ...."</p> <p>During an interview on 10/28/15 at 12:05 p.m., LPN #3 indicated she should have</p>			

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	<p>disinfected the glucometer after she performed the glucometer for Resident #58 instead of placing it in the glucometer supply box, then placing it into the medication cart. She indicated she should have a soap dish in the medication cart to place the glucometer in after the disinfectant wipe was wrapped around it instead of laying it on top of the medication cart. She indicated she should have had a barrier under the equipment on the resident's over the bed tables. LPN #3 indicated she should have washed her hands prior to preparing and administering the insulin doses for both residents.</p> <p>A current policy titled, "Medication Administration Procedure " dated 10/4/2012, provided by the Director of Nursing (DON) on 10/29/15 at 3:55 p.m., indicated "...2. Move the med cart to the outside of the resident's room or prepare in the med room. 3. Perform hand hygiene ...."</p> <p>A current policy titled " Use of medical Gloves (Application and removal) " dated 6/9/2010, provided by the DON on 10/29/15 at 3:55 p.m., indicated, "... 3. GUIDELINES: A. Hands should be washed initially prior to putting on gloves .... "</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155556	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2015
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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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	<p>A current policy titled "Hand Washing and Hand Asepsis " dated 7/27/12, provided by the DON on 10/29/15 at 3:55 p.m., indicated, "... 3. Key Procedural Points: A. SPECIFIC TIMES HANDS MUST BE WASHED:... II. Before and after direct resident contact ... 4. ALCOHOL BASED ANTISEPTIC CLEANSER MAY BE USED DURING MEDICATION PASS ... 9. HAND HYGIENE: Hand hygiene has been cited as the single most important practice to reduce the transmission of infectious agents in health care settings and is an essential element of Standard Precautions. The term 'hand-hygiene' includes both hand-washing with either plain or antiseptic-containing soap and water, and use of alcohol-based products (gels, rinses, foams) that do not require the use of water .... "</p> <p>A current policy titled, "Cleaning of Glucometer" dated 4/23/2013, provided by the DON on 10/30/15 at 10:43 a.m., indicated "1. PURPOSE: To maintain infection control between resident use. 2. PROCEDURE: A. The Glucometer will be disinfected after completing a blood sugar using a commercial disinfectant wipe (Clorox, Lysol, Gulf South etc) and completely wiping down the glucometer so it is visible wet ... C... Air dry time is typically around 30 seconds, so you must</p>			

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	<p>re-wet the meter or wrap the wet wipe around the meter after wiping it down to ensure the proper contact time is achieved as directed by the manufacturer. D. Place wrapped Glucometer in covered container and set timer for manufacturer's contact kill time. E. Once contact kill time has expired, wait and allow to air dry before re-using the glucometer. "</p> <p>3.1-18(I)</p>			