

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 02/17/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00163362.</p> <p>Complaint IN00163362 - Unsubstantiated due to lack of evidence.</p> <p>Survey Dates: February 10, 11, 12, 13, and 17, 2015.</p> <p>Facility number: 000398 Provider number: 155564 AIM number: 100291110</p> <p>Survey team: Angela Patterson, RN-TC Cheryl Mabry, RN Brooke Harrison, RN Kimberly Gines, RN Jennifer McElwee, RN</p> <p>Census bed type: SNF: 15 SNF/NF: 57 Total: 72</p>	F 000	The Mooresville facility respectfully requests paper compliance. Please accept the following plan of correction for F-Tag 242, 257, 278, 281, 282, 329, 371, 372, 514 as our credible allegation of compliance.	
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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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F 242 SS=D Bldg. 00	<p>Census payer type: Medicare: 15 Medicaid: 45 Other: 12 Total: 72</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 23, 2015; by Kimberly Perigo, RN.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure as indicated by facility policy, a resident was able to choose what time to get up in the morning according to their preferences for 1 of 5 residents who met the criteria for review of choices. (Resident #125)</p>	F 242	<p>It is the Policy of Miller's Merry Manor to honor resident's right of choice. The deficiency identified was addressed and the wake up time was changed on resident's plan of care and CNA assignment sheet. Social Services Director or designee will complete "Admission Preference Checklist"</p>	03/06/2015
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	<p>Findings include:</p> <p>Resident #125's clinical record was reviewed on 2/13/15 at 10:00 a.m. Diagnosis included, but were not limited to: unspecified joint disorder of multiple sites and unspecified peripheral vascular disease.</p> <p>On 2/10/15 at 3:11 p.m., Resident #125 indicated, "They get me up at 7 [a.m.] and I want to get up at 8 [a.m.]. They have so many to get up in the morning, but I don't want to be the first one they get up."</p> <p>The current Minimum Data Set (MDS) assessment dated 1/26/15, indicated a Brief Interview for Mental Status (BIMS) score of 9. When 8-15 was cognitively intact and interviewable. The MDS indicated, Resident #125 needed, "extensive assistance of 1 staff person for physical assist for bed mobility and transfer...."</p> <p>CNA (Certified Nursing Assistant) assignment sheet dated 2/12/15, and 2/13/15, indicated Resident #125, "... to be in bed by 7 p [p.m.]." There was no indication of what time Resident #125 wanted to get up in the morning.</p>		<p>tool (Attachment A) upon admission, and preferences checked monthly thereafter. The tool has been completed on all current residents. The resident plan of care and assignment sheets will be updated with any new preference. Any issues will be corrected immediately, recorded on the facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented. IDR Miller's Merry Manor respectfully requests to informally dispute F242 and ask that it be deleted from the survey findings. During the survey process there was not any concerns brought to our attention about resident #125's preferences. This did not allow us the opportunity to provide any further documentation or information to satisfy these concerns. While there was discussion about preferences with one surveyor, it was regarding residents other than #125. There were no other residents sited in the deficient practice. Miller's Merry Manor has a system in place to identify preferences upon admission and continually monitor changes of preferences throughout their stay. Upon admission each resident is specifically asked about preferences. On a monthly basis resident's preferences are reevaluated and updated if preferences have changed.</p>		

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	<p>On 2/12/15 at 3:00 p.m., the Admission Coordinator indicated, "I ask the residents certain questions on admission. I have a cheat sheet. It doesn't ask what times the resident wants to get up in the morning. These are questions that corporate wants me to ask and enter in the computer so it can be placed on the CNA assignment sheet. It does not address time. The CNA's would ask the residents when entering the room to get them up, if they want to get up."</p> <p>On 2/17/15 at 1:15 p.m., the Administrator indicated, "There is not a particular policy for choices. The facility goes off the original social service preference assessment and then monthly the residents are reassessed and if there are any changes the care plan is updated and the CNA assignment sheet is updated."</p> <p>On 2/17/15 at 2:10 p.m., the Social Service Director indicated, " If there is a specific preference we discuss it on the initial and quarterly conference. The questions come from the MDS which is very generic. The CNA's [Certified Nursing Assistants] get the information on their assignment sheets. Only the preferences the resident say are important are entered in the careplan, then this information would be placed on the CNA</p>		<p>Anytime resident voices a preference or a change in preferences, their care plan & CNA assignment sheet are updated to reflect that preference. Resident #125 had not voiced any concern about wake up time with staff. Resident #125 was admitted 12/31/14. Upon admission resident was interviewed by the Social Services Director about preferences. During admission the resident in question only mentioned the following concerns: clothing choice, family involvement, and privacy during phone conversations (Attachment B). The resident was interviewed 2/13/15 which is less than a month and a half from admission. The fact that the facility was not aware of this specific preference indicated that there was no deficient practice that occurred.</p>	

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	<p>assignment sheet. If it is not important than the CNA's wouldn't know the preference and it won't be care planned."</p> <p>On 2/17/15 at 2:23 p.m., the Social Service director provided a worksheet with no title nor date and indicated the worksheet is what she uses from the MDS to determine the residents preferences on admission. The form indicated, "... MDS-Section F: 1. Very 2. Somewhat 3. Not Very 4. Not at all 5. Important, but can't or no choice 6. No response ... Time to get up: ..."</p> <p>Care plan "PREFERENCES" dated 1/16/15, indicated, Resident expresses, during the assessment process, that it is important to him/her to: chose[sic] what clothes to wear, have family/friend involved in discussions re:care, to be able use phone in private. ... Goal: Resident will express that these needs are being met. ... Interventions ... Ask resident what clothing ... she would like to wear, ..."</p> <p>On 2/17/15 at 1:15 p.m., the Administrator provided policy "Resident Rights ..." revised date 12/2011, and indicated the policy was the one currently used by the facility. The policy indicated, "...QUALITY OF LIFE, ... E. Accommodations of Needs, A resident has the right to: 1. reside and receive</p>			

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F 257 SS=D Bldg. 00	<p>services in the facility with reasonable accommodations of individual needs and preferences, ..."</p> <p>3.1-3(u)(3)</p> <p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation, interview, and record review, the facility failed to ensure comfortable temperature in the private dining room for 2 of 8 residents observed during stage 1 dining observation. (Resident #125, Resident #86)</p> <p>Findings include:</p> <p>On 2/12/15 at 12:00 p.m., Resident #125 and Resident #86 were observed sitting in the private dining room with small blankets wrapped around their necks.</p> <p>During an interview, on 2/12/15 at 12:02 p.m., Resident #86 indicated, "The whole building is cold, but it's especially cold in here [dining room]. I can never seem to get warm in this place. My friend [Resident #125] is always cold, too. Just</p>	F 257	<p>It is the policy of Miller's Merry Manor to maintain a comfortable and safe temperature level. All resident have the potential to be affected by this deficient practice. All Staff in-serviced on providing comfortable and safe temperature levels using a temperature range of 71 - 81° F on 3/6/15. (Attachment C) QA tool "Facility Temperature" (Attachment D) will be completed by Maintenance Supervisor or designee daily for 2 weeks, then monthly thereafter. Any issues will be corrected immediately, recorded on the facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented IDR Miller's Merry Manor respectfully requests to informally dispute F257. We request F257 be completely deleted from the survey findings.</p>	03/06/2015

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	<p>take a look at how blue her hands are."</p> <p>Resident #125 indicated, "It's always cold in here [dining room]. I don't know why it is so cold in here. I like to have a warm drink with my lunch to help warm me up."</p> <p>On 2/12/15 at 12:50 p.m., with the Maintenance Supervisor (MS) present observed the temperature, in the private dining room on the window ledge where a draft was felt to be, to measure 54-55 degrees Fahrenheit. The temperature on the other side of the dining room by the wall had a temperature of 75 degrees Fahrenheit. The MS indicated, "The temperature in the facility should be 72-78 [degrees Fahrenheit]." There was not an appropriate air temperature available at that time. The MS indicated, he had a different thermometer but it was broken and had not been replaced.</p> <p>On 2/13/15 at 11:00 a.m., with the Administrator and MS present; with a laser air thermometer; in the private dining room indicated the temperature on the wall under the window was 64 degrees Fahrenheit. The temperature on the wall on the opposite side of the room was 73 degrees Fahrenheit. The Administrator was observed to point the thermometer at a couple of chairs in the</p>		<p>Miller's Merry Manor has a policy to maintain safe and comfortable temperatures (attachmentE). On 2/12/15 the surveyor took a handheld thermometer and placed in various places in the private dining room. She placed thermometer on fish tank and several resident tables measuring 75 degrees Fahrenheit. The surveyor then placed thermometer on the window ledge touching the window. The thermometer read 55 degrees Fahrenheit. Administrator was made aware of readings and had a discussion with both the surveyor and lead about how the reading was taken. Administrator explained that the temperature was 23 degrees Fahrenheit outside with a wind chill that makes it feel like 9 degrees Fahrenheit (Attachment F). Administrator discussed concern with touching a window/window sill with a thermometer on a cold day will not ever read the same as the air temperature in the room. Administrator asked what the reading was at the resident tables, surveyor responded 75 degrees Fahrenheit. On 2/13/15 Administrator requested to recheck dining area with laser thermometer. Administrator pointed laser at areas in room that residents would be (chairs, tables) and temperature was 72 degrees Fahrenheit. Surveyor then requested to point laser back at the window for reading.</p>	

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F 281 SS=D Bldg. 00	<p>private dining room and the temperature read 72 degrees Fahrenheit. The Administrator indicated, there was no policy on comfortable temperatures in the building.</p> <p>On 2/13/15 at 11:33 a.m., the Administrator indicated, "We were established in the 70's [1970's] so we were grandfathered in [indicating the facility was not bound by Federal regulation of comfortable room temperatures]."</p> <p>3.1-19(h)</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff remained with a resident until medication was swallowed, as the facility policy indicated, for 1 of 3 residents observed during medication administration. (Resident #26)</p>	F 281	<p>Administrator reminded surveyor how cold it was outside and pointed the thermometer at the window would read lower. On 2/13/15, Administrator discussed the regulation with the surveyors. The survey guidelines indicate that there is no explicit temperature standards for facilities certified on or before October 1, 1990. (AttachmentG) Our Facility was established in 1982. The regulation also states that temperatures may fall below 71 degree Fahrenheit for facilities in areas of the country where that temperature is exceed only during brief episodes of unreasonably cold weather. (Attachment G). All reasonable areas where the residents would be were at an acceptable temperature during both times the temperature was checked indicating no deficient practice occurred.</p> <p>It is the policy of Miller's Merry Manor to administer medications according to the guidelines set forth by the State and Federal regulations, and remain with the resident until each medication is administered completely. All resident have to the potential to be affected by this deficient practice. All nurses, including</p>	03/06/2015

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	<p>Findings include:</p> <p>On 2/13/15 at 9:44 a.m., LPN #1 was observed to mix Resident #26's Miralax (laxative) in a cup of water and leave the Miralax on the resident's bedside table. LPN #1 indicated, "[Resident #26's name], here is your p--- medicine." The resident indicated, "OK," and LPN #1 left the resident's room.</p> <p>On 2/13/15 at 9:55 a.m., the Miralax was observed on the bedside table while Resident #26 was talking on her telephone.</p> <p>On 2/13/15 at 10:05 a.m., the Miralax was observed to be untouched and remained on Resident #26's bedside table.</p> <p>On 2/13/15 10:10 a.m., Resident #26 was observed to fold her blanket. The Miralax remained on the bedside table.</p> <p>During an interview, on 2/13/15 at 10:14 a.m., LPN #1 indicated, "We usually leave her Miralax on her bedside table because she sips on it." The LPN indicated, "[Resident #26's name], take your p--- medicine." Resident #26 replied, "I will." LPN #1 was observed to leave the resident's room with the Miralax sitting on her bedside table and</p>		<p>the nurse mentioned in the deficiency, will be in-services/checked off on the Medication Administration Policy (Attachment J) on 3/6/15. One on One counseling completed with employee mentioned in deficiency. QA tool "Medication Pass Procedure" (Attachment K) will be completed with at least 6 randomly picked Nurses including all 3 shifts by DON or designee weekly for 4 week, monthly for 2 months, then quarterly thereafter. Any issues will be corrected immediately, recorded on the facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented.</p>				

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	<p>indicated, "There is one resident who has an order for Miralax to be kept at bedside, but I don't think [Resident #26 name] does."</p> <p>On 2/13/15 at 10:36 a.m., the Miralax was observed to be in the same place on the bedside table in Resident #26's room.</p> <p>During an interview, on 2/13/15 at 10:49 a.m., the DON (Director of Nursing) indicated, "No that is not appropriate." The DON was then observed to remove the Miralax from Resident #26's bedside table and took it to back the nurse's station.</p> <p>Resident #26's clinical record was reviewed, on 2/13/15 at 10:54 a.m. The annual MDS (Minimum Data Set) assessment, dated 12/22/15, indicated Resident #26 required extensive assistance with eating and drinking. Diagnosis included, but were not limited to: dementia, renal failure, and constipation. The physician's orders did not indicate an order for the resident to self-administer medications at bedside.</p> <p>On 2/13/15 at 11:00 a.m., the DON provided the "Constipation" care plan for Resident #26, dated 8/11/10, and indicated it was the resident's current care plan. The care plan indicated, "Focus:</p>			

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	<p>Potential for Constipation....</p> <p>Interventions/Tasks: Administer laxative and/or stool softeners as ordered. ... Miralax may be kept at bedside. Date initiated 1/30/14 and revised on 2/13/15. ..." All of the Constipation care plan interventions, excluding the Miralax intervention, had an initiation date of 8/11/10 and did not have any revision dates.</p> <p>A review of the history for the Miralax care plan interventions indicated the following:</p> <p>"Miralax may be keep at bedside" had a created date of 2/13/15. "Miralax may be kept at bedside" had a revision date of 2/13/15.</p> <p>During an interview on 2/13/15 at 2:51 p.m., the DON did not indicate a reason for the discrepancy between the Miralax initiated date and the created date for the intervention. The DON indicated, "That is strange. I can see why that is confusing."</p> <p>On 2/13/15 at 11:00 a.m., the Administrator provided the Medication Administration Procedure, dated 10/4/12, and indicated it was the policy currently being used by the facility. The policy indicated, "...14. Transport the</p>			

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F 282 SS=D Bldg. 00	<p>medications to the resident and keep in sight at all times. ...21. Remain with the resident until each medication is swallowed. never leave medication with the resident."</p> <p>3.1-35(g)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to implement the care plan and fall precautions for 1 of 3 residents reviewed for falls (Resident #79).</p> <p>Findings include:</p> <p>The clinical record for Resident #79 was reviewed 02/13/2015 at 8:55 AM. The diagnoses included, but were not limited to, depressive disorder, generalized anxiety disorder, chronic airway obstruction (COPD), adult failure to thrive, and asthma.</p> <p>The clinical record indicated Resident #79 had falls on the following dates,</p>	F 282	<p>It is the policy of Miller's Merry Manor to follow each resident's written plan of care. All Nursing staff will be in-serviced on Safety Check sheet (Attachment W) on 3/6/15. This form has been revised to include the Charge Nurse sign off safety sheet every shift to ensure safety checks are completed as care planned. Safety Check Sheet QA tool (Attachment L) will be completed by DON or designee daily for 2 weeks, then weekly for 4 weeks then monthly thereafter. Any issues will be corrected immediately, recorded on the facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented.</p>	03/06/2015

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	<p>11/16/2014, 1/14/2015, 1/28/2015, and 2/2/2015. The record indicated the falls were without injury and occurred when the resident was self ambulating to the bathroom.</p> <p>The quarterly Minimum Data Set (MDS) assessment completed 11/14/2014, indicated Resident #79 had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident is cognitively intact. The resident was assessed as requiring one person physical assist and requiring a rolling walker for ambulation.</p> <p>The Care Plan initiated on 5/16/2013, titled "Fall Risk" indicated, "...resident has weakness, unsteady gait, hx (history) of falls with injury and requires up to extensive assist with transfers..." Revised on 1/28/2015, indicated the interventions included "... Encourage and assist with wearing non-skid-foot-wear, encourage res (resident) to ask for assistance,... reassess fall risk factors at least quarterly,... safety checks-every hour..."</p> <p>Review of the safety check list provided by LPN #3 on 2/13/2015 at 2:30 PM, indicated the check list was initiated on 2/4/2015. The resident was to be checked every 30 minutes for 2 weeks. The check list lacked documentation of safety</p>			

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	<p>checks being conducted on Resident #79 on the following dates and times: 2/5/2015 from 8:30 AM to 10:00 AM and 11:00 AM to 12:30 PM; on 2/7/2015 from 12:30 PM to 2:30 PM; on 2/12/2015 from 7:00 AM to 3:00 PM; and on 2/13/2015 from 7:30 AM to 2:30 PM.</p> <p>An interview with LPN #3 on 02/13/2015 at 2:23 PM, indicated the 30 minute safety checks were implemented following Resident #79's fall on 2/2/15. LPN #3 indicated the gaps in the safety check log meant the checks had not been completed.</p> <p>On 2/13/2015 at 11:00 AM, the Administrator provided the policy titled, "Fall Management Procedure dated 8/28/2014, and indicated the policy was current. Review of the policy indicated, "... 1. Purpose A. To assess all residents for risk factors that may contribute to falling and to provide planned interventions identified by the team as appropriate for resident use in maintaining or returning to the highest level of physical, social, and psychosocial functioning as possible..."</p> <p>3.1-35(g)(2)</p>			

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F 329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review the facility failed to implement non pharmacological interventions prior to administering an anti anxiety medication and failed to assess the effectiveness of the anti anxiety medication for 1 of 5 residents reviewed for effectiveness of the unnecessary medication use. (Resident #79).</p>	F 329	<p>It is the policy of Miller's Merry Manor the each resident's drug regimen is free of unnecessary drugs. All residents receiving PRN psychotropic medications could be affected by this deficient practice. All Nurses will be in-services on 3/6/15 (Attachment C) on the facility process to utilize non-pharmacological intervention prior to administering any psychotropic medication ordered on an as needed basis. . Effectiveness of</p>	03/06/2015
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	<p>Findings include:</p> <p>The clinical record for Resident #79 was reviewed 02/13/2015 at 8:55 AM. The diagnoses included, but were not limited to, depressive disorder, generalized anxiety disorder, chronic airway obstruction (COPD), adult failure to thrive, and asthma.</p> <p>The quarterly minimum data set (MDS) dated 11/14/2014, indicated Resident #79 had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident is cognitively intact.</p> <p>The care plans lacked documentation of anxiety symptoms shown by resident and non pharmacological approaches to offer prior to administration of the Valium.</p> <p>The record indicated a physician order dated 9/15/2014, for Valium (anti anxiety medication) 5mg (milligrams) every 8 hours as needed for anxiety. The record indicated resident #79 received Valium 5mg (milligrams) on the following dates and times: 2/2/2015 at 8:08 PM; 2/3/2015 at 9:10 PM; 2/4/2015 at 9:15 PM; 2/5/2015 at 8:00 PM; 2/6/2015 at 9:30 PM; 2/7/2015 at 9:00 PM; 2/8/2015 at 8:00 PM; 2/9/2105 at 9:10 PM; 2/10/2015 at 9:10 PM; and 2/11/2015 at 9:00 PM.</p>		<p>Non-Pharmalogical interventions will be documented on the Medication Administration Record. Medication will only be given if other interventions are ineffective. Unnecessary Drug QA Tool (Attachment M) will be completed by the DON or designee daily for 2 weeks, then weekly for 4 weeks, then monthly thereafter. Any issues will be corrected immediately, recorded on the facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented.</p>	

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	<p>The record lacked documentation of effectiveness of the medication for 2/2/2015, 2/4/2015, 2/7/2015, 2/8/2015, and 2/9/2015.</p> <p>The record lacked documentation indicating whether Resident #79 had requested the Valium.</p> <p>Interview with Director of Nursing (DON) on 2/13/2015 at 10:05 AM, indicated the resident has anxiety at bedtime due to her COPD (Chronic Obstructive Pulmonary Disease). The non pharmacological approaches offered before given the Valium were to offer the Resident resident water and assist resident to the bathroom. The DON indicated there were was no other documentation available regarding the effectiveness of the medication.</p> <p>On 2/13/2015 at 11:00 AM, the Administrator provided the policy titled, " Psychotropic Medication Use: dated 2/4/2008...Procedure:...2. On-going monitoring of target behaviors will be documented as they occur in the clinical record along with the interventions used to reduce and the results... Anxiolytic (anti-anxiety medication)... Target behaviors must be clearly identified and monitored. Episodes will be documented</p>			

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F 371 SS=F Bldg. 00	<p>in the clinical record as they occur along with the results of the interventions used to reduce the behavior..."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</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, as indicated by the facility policy, Center for Disease Control, and the 410 IAC 7-24 Retail Food Establishment Sanitation Requirements cold foods were served at the proper temperature in that the cold food temperature measured at 44 and 48 degrees Fahrenheit; staff used proper handwashing in the kitchen; food was discarded from 1 of 1 dry storage room, 1 of 1 walk in refrigerator, 1 of 1 walk in freezer , and kitchen storage shelf when the expiration date had passed; sanitary conditions while preparing food in that a cook placed a clean pot in a dirty sink then used the pot to scoop food for</p>	F 371	<p>It is the policy of Miller's Merry manor to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. None of the residents involved in the identified deficient hand washing practice experienced and negative side effects or outcomes. An all staff in-service will be held on 3/6/15 (Attachment C) which include the review of our hand washing policy and procedure. At this in-service, all staff, including the staff members identified in the findings were in-serviced on this policy and procedure. To ensure on-going compliance, the</p>	03/06/2015

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	<p>preparation; the length of time to let the thermometer temperature to hold for accuracy; and staff distributed and served food to residents under sanitary conditions and performed hand washing during food service for 3 of 3 residents observed during Stage 1 dining observations. This deficient practice had the potential to affect 71 of 71 residents served from the kitchen. (Cook #1, Cook #2, Cook #3) (Resident #11, Resident #22, Resident #27)</p> <p>Findings include:</p> <p>On 2/10/15 at 9:50 a.m., the following was observed during the kitchen tour with the Dietary Manager (DM) present:</p> <p>1). A box with a bag of open rice was on the shelf in the dry storage room, without an open date.</p> <p>2). A 10 pound open bag of coconut breading was on the shelf with a received date of 4/16/14, and an open date of 4/18/14.</p> <p>The DM indicated, "I don't see a used by date so I'll just take it out." The DM was observed to discard the bag at that time.</p> <p>In the walk in refrigerator the following was observed:</p>		<p>Infections Control Nurse or designee will be completing the QA tool entitled "Hand Washing" (Attachment N) with at least 6 randomly picked employees, including all meals, weekly for 4 week, monthly for 2 months, then quarterly thereafter. Any issues will be corrected immediately, recorded on the facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented. The Dietary Manager conducted Potentially Hazardous Foods (Attachment O) on 2/26/15. Dietary Manager or designee will also conduct QA tool "Food Safety Sanitation Checklist" (Attachment P) weekly for 4 weeks, then monthly thereafter to monitor compliance on sanitation. These results will be discussed at monthly QA committee meeting and new identified trends or concerns will be addressed by the committee as appropriate. It is the policy of Miller's Merry Manor that the food service area be maintained to prevent the spread of infection and shall assure the dumpster area is kept clean and all trash bags are in the dumpster and dumpster lids are closed. (Attachment Q) Staff in-serviced on Waste Disposal policy (Attachment C) on 3/6/15. Dietary Manager or designee will also conduct QA tool "Food Safety Sanitation Checklist" (Attachment P) weekly for 4</p>	

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	<p>3). A tub of leftover ham with a used by date of 2/3/15. The DM was observed to discard the ham at that time.</p> <p>4). 2 whole hams on a cookie sheet with a thaw date of 2/4/15.</p> <p>5). 1 1/2 deli turkey in a container with an open date of 2/4/15.</p> <p>The DM indicated, "The policy for discarding leftovers was 72 hours after open."</p> <p>In the walk in freezer the following was observed:</p> <p>6). A open bag of chicken tenders was observed on the shelf. There was no open nor used by date. The DM indicated, "It should have an open date on it."</p> <p>7). On a shelf in the kitchen the following spices were observed with expired dates:</p> <p>Leaf thyme with open date of 11/9/11 Bay leaves with an open date of 1/28/12 Dill weed with an open date of 6/1/12 Ground rosemary with an open date of 12/28/11 pumpkin pie with an open date of 11/9/11</p>		<p>weeks, then monthly thereafter to monitor compliance on sanitation. These results will be discussed at monthly QA committee meeting and new identified trends or concerns will be addressed by the committee as appropriate It is the policy of Miller's Merry Manor that all food be prepared and served in a clean, sanitary, and safe manner to conserve maximum nutritive value, develop and enhance flavor, and be free of injurious organisms and substances. (Attachment) The Dietary Manager conducted hand washing & Food Safety Review (Attachment S) 2/11/15. Dietary Manager or designee will also conduct QA tool "Food Temperature Review" (Attachment T) daily for 2 weeks, weekly for 4 weeks, then monthly thereafter to monitor compliance on sanitation. These results will be discussed at monthly QA committee meeting and new identified trends or concerns will be addressed by the committee as appropriate Dietary Manager or designee will also conduct QA tool "Food Labeling and Dating Audit" (Attachment U) daily for 2 weeks, weekly for 4 weeks, then monthly thereafter to monitor compliance on sanitation. These results will be discussed at monthly QA committee meeting and new identified trends or concerns will be addressed by the committee</p>	

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	<p>ground nutmeg with an open date of 9/11/11</p> <p>The DM indicated, "The spices are only good for 2 years."</p> <p>8). On 2/10/15 at 11:50 a.m., Cook #1 was observed to puree pork cutlets. She was observed to put the spoon in the sink and reached back into the sink to get the spoon back out. She left the spoon in the sink walked over to the end of the counter and moved the garbage can out of the way with her bare hands. No handwashing was observed at that time. She opened the drawer and removed a spatula. She walked back over to the prep area and spooned the pureed meat into a metal pan. Cook #1 indicated, "I should wash my hands before I go do the food, basically anytime you touch your face, hands or anything you should handwash. I did not wash my hands after touching the garbage can. I don't even remember touching it."</p> <p>9). Cook #1 was observed to clean the puree pot in the 3 compartment sink. She walked over to the prep table with the clean puree pot and placed it on the prep table. She was observed to walk over to the sink and handwash for 5 seconds under the water. The Dietary Manager (DM) indicated to Cook #1 to rewash her</p>		as appropriate	

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	<p>hands and to watch the clock the entire time. Cook #1 indicated, "I didn't know [referring to watching the clock for accuracy of the time]." The DM indicated to Cook #1, "Wash your hands 20 seconds and then rinse."</p> <p>10). On 2/10/15 at 12:10 p.m., Cook #1 was observed to take food temperatures and not letting the thermometer stop and hold for 15 seconds. Cook #1 indicated, "I have never waited for the thermometer to stop and hold the temperature. I don't know how long I should hold it for [indicating the temperature on the thermometer]."</p> <p>11). On 2/10/15 at 12:30 p.m., the DM was observed to take the temperature of an individual container of yogurt. The yogurt was on the dining room counter in a pan of ice. The temperature was 48 degrees Fahrenheit. The temperature on a Mighty shake was 44 degrees Fahrenheit. The DM indicated, "The temperatures should be under 44 degrees Fahrenheit." The DM was observed to removed and discard the yogurt, Mighty shake and 5 other cold items in the pan.</p> <p>12). On 2/12/15 at 12:00 p.m., Cook #2 was observed to scoop beans out of a large pot with a smaller pot, then to place the beans in the puree container. She was</p>			

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	<p>observed to put the small pot in the dirty sink next to where she was pureeing. She picked up the pot out of the dirty sink and dipped it into the pot with the beans. Cook #2 indicated, "The sink is not clean. I need to dump those beans." Cook #2 was observed to walk into the dishwashing area and dump the pureed beans.13. In the main dining room, on 2/10/15 at 12:48 p.m., Cook #3 was observed to touch her face with her bare hands.</p> <p>14. On 2/10/15 12:49 p.m., Cook #3 was observed to enter the kitchen from the main dining room, walk to a refrigerator, pull out a carafe of lemonade, and return to the main dining room. No handwashing was observed before or after entering the kitchen. Cook #3 indicated, "No, I didn't wash my hands," and she was observed to hand out a glass of lemonade to Resident #11 and Resident #22.</p> <p>During an interview on 2/10/15 at 1:33 p.m., Cook #3 indicated, "You should wash your hands every time you walk into the kitchen from the dining room or if they are soiled."</p> <p>15. On 2/10/2015 at 12:35 p.m. during lunch observation in the main dining room, the Director of Nursing (DON) was observed to hand wash (friction) for</p>			

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	<p>10 seconds then sit and assist Resident #27 with lunch.</p> <p>During an interview on 2/17/2015 at 1:45 p.m., the DON indicated, "I wash my hands upon arriving in the dining area, prior to serving. I use hand sanitizer after every 3rd tray if nothing has been touched, any time you would touch yourself/hair, and when coughing or when touching anything dirty or rubbing your nose. I wash my hands for 20 seconds but the facility has been saying to do if for 30 seconds just to be safe. Handwashing is 20 seconds which consist of putting soap on and rubbing your fingers and thumbs."</p> <p>On 2/13/15 at 11:00 a.m., the Administrator provided the policy, "Food Protection and Storage" dated 10/15/2009, and indicated the policy was the one currently used by the facility. The policy indicated, "I. ...It is policy that all food shall be stored and protected under safe and sanitary conditions. [Reference: 410 IAC 7-24] ... VII. Open boxes, containers of food are securely enclosed, labeled and dated, ...X. Food not in original containers are ... dated, and stored, ...XIV. ...Spices may be kept up to 2 years. ...Planned left over food ... labeled and dated. Any left over foods not frozen need to be used within 3 days</p>			

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	<p>or discarded, ...XVII. ... frozen food will be used within 6 months. ... XIV. Food items in the refrigerator are covered, labeled, and dated. Precooked items are are used or discarded in 3 days. ...food ... Food ... stored in refrigerator will be used or destroyed within recommended shelf life or 6 months. ..."</p> <p>On 2/17/15 at 1:10 p.m., the Administrator provided the policy, "Handwashing" dated 1/30/2013, and indicated the policy was the one currently used by the facility. The policy indicated, "...It is policy that all dietary employees know and understand when handwashing is required and how to properly wash their hands. [Reference 410 IAC 7-24- Sections 128 thru 130], ... employees shall wash their hands ... at the following times: ... F. after handling soiled surfaces, equipment or utensils. G. During food preparation, ... to prevent cross contamination when changing task. ... Proper Handwashing: ... D. Rub hands vigorously together for 20-30 seconds, .. E. Rinse thoroughly under running water....J. After engaging in other activities that contaminate the hands."</p> <p>On 2/17/15 at 1:10 p.m., the Administrator provided the policy, "Food and Beverage Temperature Testing" dated 8/20/2012, and indicated the policy</p>			

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	<p>was the one currently used by the facility. The policy indicated, "... B. The cold food tested is 41 degrees F (Fahrenheit) or below."</p> <p>On 2/18/15 at 10:30 p.m., review of Center for Disease Control at www.cdc.gov/handwashing/, dated December 16, 2013 indicated, " When should you wash your hands? Before, during, and after preparing food, ...After touching garbage, ...How should you wash your hands? Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. ... "</p> <p>On 2/17/15 at 10:37 p.m., review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24," dated November 13, 2004, indicated, "Hand cleaning and drying procedure ... (a) Food employees shall, except as specified in section 343 (c) of this rule, clean their hands and exposed portions of their arms with a rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water ... When to wash hands (a) Food employees shall clean their hands and exposed portions of their arms as specified ... immediately</p>			

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	<p>before engaging in food preparation. ... and the following... (6) After handling soiled surfaces, equipment, or utensils ... after engaging in other activities that contaminate the hands."</p> <p>On 2/17/15 at 10:37 p.m., review of the 410 IAC 7-24-187 dated November 13, 2004, indicated "Potentially hazardous food;hot and cold holding, ...[a] Except during preparation, cooking, or cooling, ...potentially hazardous food shall be maintained as follows: ...[2] At a temperature specified in the following: [A] At forty-one [41] degrees Fahrenheit or less. ..."</p> <p>On 2/18/15 at 10:03 a.m., review of the 410 IAC 7-24-182 dated November 13, 2004, indicated, "Cooking of raw animal foods, Sec. 182 (a) (D)(3) The minimum cooking temperatures and holding times at a specified temperature are as follows: MINIMUM COOKING TEMPERATURES AND HOLDING TIMES AT SPECIFIED TEMPERATURES : 165 degrees F [Fahrenheit] for 15 seconds, Poultry and foods containing poultry, stuffed meat, fish or pasta; stuffing containing fish or meat; food containing game animals. ..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F 372 SS=C Bldg. 00	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>Based on observation, interview, and record review, the facility failed to ensure as indicated by facility policy and the 410 IAC Retail Food Establishment Sanitation Requirements Manual the garbage was properly disposed of for 1 of 1 outdoor waste receptacles.</p> <p>Findings include:</p> <p>On 2/12/15 at 3:00 p.m., during an outside tour with the Dietary Manager present indicated one of the six dumpster lids was open completely and 1 of the 6 lids was slightly open. Clear trash bags were observed to be hanging out of the trash dumpster. The DM was observed to push the trash down into the dumpster and shut both lids. The DM indicated, "The lids should be closed."</p> <p>On 2/17/15 at 1:10 p.m., the Administrator provided policy "Garbage and refuse" dated 10/15/2009, and indicated the policy was the one currently used by the facility. The policy indicated, "It is policy that effective measure shall be utilized for protection against rodents,</p>	F 372	<p>It is the policy of Miller's Merry Manor that the food service area be maintained to prevent the spread of infection and shall assure the dumpster area is kept clean and all trash bags are in the dumpster and dumpster lids are closed. Staff in-serviced on Waste Disposal policy (Attachment C) on 3/6/15. Dietary Manager or designee will also conduct QA tool "Food Safety Sanitation Checklist" (Attachment P) weekly for 4 weeks, then monthly thereafter to monitor compliance on sanitation. These results will be discussed at monthly QA committee meeting and new identified trends or concerns will be addressed by the committee as appropriate IDR Miller's Merry Manor respectfully requests to informally dispute F372. Since the survey findings only identify 1 incident we ask that F372 be deleted. On 2/12/15 the surveyor and Dietary Manager went outside to check the dumpster. 1 of 6 lids was observed open. The Dietary Manager closed the dumpster lid. While the Surveyor and DM were having a discussion at the dumpster a gust of wind blew the</p>	03/06/2015

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F 514 SS=D Bldg. 00	<p>... and other insects. ... B. Dumpster area is clean and clutter free. The lid is kept shut. C. Trash cans are clean and have lids on."</p> <p>On 2/18/15 at 10:00 p.m., review of "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24," dated November 13, 2004, indicated, ...410 IAC 7-24-385 Outside receptacles Sec. 385. (a) Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the retail food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers. ..."</p> <p>3.1-21(i)(5)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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</p>		<p>same dumpster lid open again. Mooresville weather report shows wind gusts up to 29 mph (Attachment F) The survey did not indicate any other times the lid was open. Seeing that the surveyor witnessed the wind blowing the dumpster lid open, coupled with the fact of 29 mph gusts of wind we ask that the deficiency be deleted.</p>				

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	<p>care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review, the facility failed to ensure assessment for self-administration of medication was completed, as the facility policy indicated, for 1 of 3 residents observed during medication administration. (Resident #26)</p> <p>Findings include:</p> <p>During a medication administration, on 2/13/15 at 9:44 a.m., LPN #1 was observed to mix Resident #26's Miralax (laxative) in a cup of water and leave the Miralax on the resident's bedside table. LPN #1 left the resident's room.</p> <p>On 2/13/15 at 11:01 a.m., the DON (Director of Nursing) indicated, "I don't know if the resident's have to have an order for meds [medications] to bed kept at bedside."</p> <p>Resident #26's clinical record was reviewed, on 2/13/15 at 10:54 a.m. The annual MDS (Minimum Data Set) assessment, dated 12/22/15, indicated Resident #26 required extensive assistance with eating and drinking. Diagnosis included, but were not limited to: dementia, renal failure, and</p>	F 514	<p>It is the policy of Miller's Merry Manor to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. All nurses were in-serviced on facility policy regarding leaving medications at bedside on 02/20/15 by ADON. All Nurses will be in-serviced on the policy titled Self Administration of Meds Procedure & Assessments (Attachment V) on 3/6/15. The facility currently has no residents self administering their own medications. All self medication requests will be brought to the attention of the DON for further review and assessment. The nurse involved in the deficient practice was educated one on one at the time of the finding. All nurses, including the nurse mentioned in the deficiency, will be in-services/checked off on the Medication Administration Policy (Attachment J) on 3/6/15. QA tool "Medication Pass Procedure" (Attachment K) will be completed with at least 6 randomly picked Nurses including all 3 shifts by DON or designee weekly for 4 week, monthly for 2 months, then quarterly thereafter. Any issues will be corrected immediately, recorded on the facility QA</p>	03/06/2015

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	<p>constipation. The physician's orders did not indicate an order for the resident to self-administer medications at bedside.</p> <p>On 2/17/15 at 1:52 p.m., LPN #4 indicated, "I don't see a self-administration assessment for Resident #26. That's the first time I've ever seen that option on the charting. I never even know that existed. We always just leave it [Miralax] at bedside."</p> <p>On 2/17/15 at 1:10 p.m., the Administrator provided the Self Administration of Meds Procedure & Assessments policy, dated 3/1/01, and indicated it was the policy currently being used. The policy indicated, "...C. PROCEDURE-GENERAL: 1.) Any resident expressing a desire to self-administer medications must review and sign a Self-Administration request form. 2. An assessment of the residents abilities to self-administer meds will be completed prior to initiation of training....D. PROCEDURE-ASSESSMENT FOR SELF-ADMINISTRATION of MEDICATION:2. For each medication to be self-adm [administered], the residents ability must be assessed by answering each of the 11 questions on the assessment for self Adm. Of Med Form.... 5. If the team determines that the</p>		Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented. Any issues will be corrected immediately, recorded on the facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented.				

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	<p>resident is able to selfadm (sic), a Physicians order must be obtained for MKAB for self-administration....9. Residents self-adm of medications documentation....must be assessed weekly in the narrative nursing notes. 10. Complete assessment screen quarterly."</p> <p>3.1-50(a)(1)</p>				