

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155589	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2023
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SCHOOL ST CULVER, IN 46511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00400398. Complaint IN00400398 - Substantiated. Federal/State deficiencies related to the allegations are cited at F760. Survey dates: February 9 & 10, 2023 Facility number: 000489 Provider number: 155589 AIM number: 100400398 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 12 Medicaid: 28 Other: 9 Total: 49 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.	F 000			
F 760 SS=G	Quality review completed 2/23/23. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a significant	F 760	Past noncompliance: no plan of correction required.		

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155589	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2023
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SCHOOL ST CULVER, IN 46511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	<p>Continued From page 1</p> <p>medication did not occur for 1 of 5 residents reviewed for medication errors. (Resident B)</p> <p>Finding includes:</p> <p>On 2/9/23 at 11:07 A.M., a review of the clinical record for Resident B was conducted. The record indicated the resident was admitted on 1/18/23. The resident's diagnoses included, but were not limited to: diabetic, fractured left hip with surgical repair, chronic atrial fibrillation and hypertension.</p> <p>The Admission Minimum Data Set (MDS), dated 1/25/23, indicated the resident had moderately impaired cognition and had been administered insulin 7 days a week.</p> <p>A care plan, dated 1/18/23, indicated the resident had diabetes and had the potential for hyper/hypoglycemia. The interventions included, but were not limited to: give medications and monitor blood sugars as ordered.</p> <p>The Physician Order, dated 1/18/23, indicated the resident was to be administered Lispro (a rapid-acting insulin which covers insulin needs for meals) three times a day (7:00 A.M., 11:00 A.M. & 4:00 P.M.) per sliding scale, for diabetes-15 minutes before meal/snack. Sliding scale indicated for blood sugars at: 150-200 administer 2 units, 201-250 administer 4 units, 251-300 administer 6 units, 301-350 administer 8 units, 351-400 administer 10 units and 401-450 administer 12 units. If blood sugar is less than 70 or greater than 450 call the Medical Doctor.</p> <p>The Medication Administration Record, for January 2023, indicated the resident was administered 2 units of Lispro, at 4:00 P.M., and</p>	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155589	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2023
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SCHOOL ST CULVER, IN 46511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	<p>Continued From page 2</p> <p>his blood sugar was 180.</p> <p>A Progress Note, dated 1/28/23 at 9:01 P.M., indicated resident "...given Toujeo 100 units sub q [subcutaneous injection], BS [blood sugar] checked 147...MD [Medical Doctor] notified, N.O [new order] received to send res [resident] to ER [Emergency room]...."</p> <p>A self-reported incident #81, dated 1/28/23 at 9:01 P.M., indicated nurse RN 2 accidentally administered Resident B the wrong dose of insulin and was sent to the hospital. The incident indicated RN 2 would be educated on the proper administration of medication. The follow-up indicated all nursing staff in-serviced on medication administration.</p> <p>A form titled, "Medication and Treatment Error Report", dated 1/28/23 at 9:21 P.M., indicated Toujeo (a long acting insulin which covers insulin needs for about one full day and was often combined with rapid-or-short-acting insulin) 100 units was administered to the wrong resident by RN 2. The resident's medical doctor and family were notified of the error. The MD ordered the resident to be sent to a local emergency room for an evaluation and treatment.</p> <p>A Quality Assessment/Improvement Program, dated 2/4/23, indicated RN 2 was observed during a medication pass to ensure she followed the following procedures: " ...Medications verified against MD [Medical Doctor] order on MAR [Medication Administration Record] when being prepared. Medications administered per MD [Medical Doctor] orders using the 5 rights: Right Patient</p>	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155589	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2023
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SCHOOL ST CULVER, IN 46511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	<p>Continued From page 3</p> <p>Right Drug Right Dose Right Route Right time</p> <p>Medications signed off on MAR after administration" The Quality Assessment/Improvement Program indicated RN 2 was instructed to take medication cart to resident's room and park it just outside of the room. RN 2 was educated on the facility's policy and procedure regarding subcutaneous injections.</p> <p>An Emergency Room (ER) Department Note, dated 1/28/22, indicated the patient presented to the ER for unintentional administration of insulin. Patient received 100 units of insulin glargine (Toujeo). Poison Control was contacted and recommended lab work and to monitor blood glucose for 30 hours. The patient's blood glucose was 140 upon arrival at ER.</p> <p>The Discharge Summary, dated 2/1/23, indicated " ...the patient initially was maintained on continuous D5 [intravenous sugar solution] with frequent blood sugar checks without further dropping. D5 was discontinued 2 days ago and patient sustained his blood sugar without further dropping. Other blood work was stable on admission. He will be discharged back to his facility"</p> <p>During an interview, on 2/10/23 at 9:23 A.M., the Director of Nursing (DON) indicated the error occurred during the bedtime insulin administration. Resident B did not have an order, for evening dose, of insulin; however Resident C was the resident who should of received the 100 units of Toujeo insulin, per the physicians order.</p>	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155589	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2023
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SCHOOL ST CULVER, IN 46511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	<p>Continued From page 4</p> <p>The DON indicated RN 2 had another nurse check the dosage amount, which RN 2 had drawn up, but then went into the wrong room and administered the Toujeo insulin to Resident B, instead of Resident C. RN 2 immediately realized, after administering the insulin, she had made a mistake. RN 2 was in-serviced the night of the incident over the phone. The DON indicated RN 2 had not taken the cart to outside of the resident's room. The RN 2 returned to work on 2/4/22 and at that time she was required to perform a return demonstration regarding insulin administration.</p> <p>During an interview, on 2/10/23 at 10:50 A.M., the resident was lying in bed, he had just come from therapy. He was alert to self but not to place and unsure what date it was. He indicated he had been to the hospital and showed me his finger and indicated he had hip surgery. Resident B had no concerns about taking insulin and indicated he didn't take it anymore.</p> <p>On 2/10/23 at 9:45 A.M., the DON provided a policy titled, "Injection - Subcutaneous Procedure", dated 3/2011, and indicated the policy was the one currently used by the facility. The policy indicated " ...Administering a Subcutaneous Injection Goal: The patient receives medication via the subcutaneous route. 1. Gather equipment. 2. Move the med [medication] cart to the outside of the resident's room or prepare in med room ...6. Read the administration record and select the proper medication from the resident's med [medication] stock. 7. Compare the label with the administration record ...14. Identify the resident one of three ways: Check the picture in the med [medication] book</p>	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155589	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2023
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SCHOOL ST CULVER, IN 46511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	<p>Continued From page 5</p> <p>Ask the resident to state name Ask co-worker who knows the resident"</p> <p>The Past Noncompliance Significant Medication Error began on 1/28/23. The Significant Medication Error was corrected on 1/29/23 when the facility had completed the investigation, and all staff in-servicing was completed regarding medication administration, five rights verification, and medication administration observations were conducted</p> <p>This Federal tag relates to complaint IN00400398.</p> <p>3.1-48(c)(2)</p>	F 760			