| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075295 | A. BUILDING _____ B. WING _____ | 11/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILLER MEMORIAL COMMUNITY | 360 BROAD STREET MERIDEN, CT 06450 |

JAN 20 2012

| (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 253 SS=D | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview for one of three resident units (Edward's Pavilion), the facility failed to maintain ceiling tiles in a clean and safe manner. The findings include:<br><br>Observation on 11/14/11 at 9:15 am on the Edward Pavilion (west wing) noted nine (9) water stained ceiling tiles with two of the nine ceiling tiles bulging. Interview at that time with the Environmental Specialist indicated the ceiling tiles were not part of a preventative maintenance program, but are checked after rain storms. Interview on 11/16/11 at 10:00 am with the environmental specialist indicated the roof on the Edward Pavilion (west wing) leaks and needs to be replaced. The Environmental Specialist indicated the ceiling tiles were replaced on 11/14/11 and indicated the facility did have plans to replace the roof. | F 253 | This Plan of Correction constitutes our written notification of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that the deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal Law.<br>F 253<br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>A. The condition of the ceiling tiles will be monitored.<br>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br>A. All residents have the potential to be affected and stained ceiling tiles will be replaced as necessary. | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | F 309 | 3. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and,<br>A. A quote has been obtained from DiGiorgi Roofing for $65,500 to replace | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/9/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075295 | A. BUILDING _____ B. WING _____ | 11/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILLER MEMORIAL COMMUNITY | 360 BROAD STREET MERIDEN, CT 06450 |

| (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 309 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the clinical record, facility policy and interviews for one sampled resident reviewed for pain (Resident #136), the facility failed to ensure a complete pain assessment was conducted. The findings include:<br><br>Resident #136's diagnoses included diabetes mellitus and anxiety. The Minimum Data Set dated 10/8/10 identified the resident was alert and oriented, required limited to total assistance with activities of daily living, and experienced pain frequently. The resident care plan dated 11/15/10 identified an alteration in comfort as evidenced by chronic low back pain. Interventions included to medicate as ordered, monitor and document the effects of medications, provide diversional activities, assess, monitor, record and report changes to the physician. The physician's order dated 1/17/11 identified to administer Tramadol 50 mg via a peg tube every six hours and Acetaminophen 650 mg every four hours as needed for general discomfort. The physician's order dated 1/20/11 directed to discontinue ambulation with a four wheeled walker and to start stand pivot transfers with an assist of two persons. The January 2011 medication kardex noted R #136 received Acetaminophen on 10 occasions for right hip pain and/or discomfort. | F 309 | that portion of the roof. Due to the winter weather conditions, the roof replacement will be done in the early spring. The ceiling tiles will be monitored and replaced as needed until the roof gets replaced.<br>4. How the facility will monitor its corrective action(s) to ensure that the deficient practice will not recur, (i.e., what quality assurance or other program will be put into place to monitor the continued effectiveness of the systemic change).<br>A. The Environmental Services Manager or designee will randomly monitor the ceiling tiles.<br>5. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction for each deficiency and the completion date of each component.<br>A. Environmental Services Manager<br><br>F 309<br>1. What corrective action(s) will be accomplished for those | 05/30/2012 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075295 | A. BUILDING _____ B. WING _____ | 11/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILLER MEMORIAL COMMUNITY | 360 BROAD STREET MERIDEN, CT 06450 |

| (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 309 | Continued From page 2<br>The nurse's assessment dated 1/17/11 identified a 12.5 cm by 4.4 cm bruise on the right hip with the surrounding skin yellow in color. The assessment identified R #136 was experiencing pain in the legs and the bottom of the feet and an x-ray of the right hip was negative for fracture. The nurses' notes from 1/17/11 through 1/29/11 identified 17 shifts when R #136 identified pain in the lower extremity, right hip and/or lower back, however, failed to identify an assessment of the areas were conducted. The Advanced Practice Registered Nurses (APRN) progress note dated 1/28/11 noted tenderness and pain in the right hip on palpation and rotation. R #136 was unable to ambulate independently secondary to increased pain when pressure was placed on the foot. A subsequent x-ray was obtained that identified an impacted angulated subcapital right femoral neck fracture and the resident was transferred to the hospital for treatment. Review of the clinical record and interview with the Director of Nurses (DNS) on 11/16/11 at 12:45 pm failed to reflect a physical and/or visual assessment was conducted when the resident identified pain on 1/17/11 until 1/28/11. The DNS indicated when a resident complains of pain the expectation is to visualize the area, perform range of motion, and to look for any abnormality. Review of facility pain management policy and procedure directed in part to conduct an assessment of the area when pain is present. | F 309 | residents found to have been affected by the deficient practice?<br>A. Resident #136 expired on 03/16/2011.<br>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br>A. All residents who have bruising with pain have the potential to be affected and they will have a physical and/or visual assessment conducted by a nurse.<br>3. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and,<br>A. All licensed staff will be reeducated to perform and document physical and/or visual assessments along with their pain assessments for any resident who has bruising with pain as well as review the pain management policy | |
| F 332 SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater. | F 332 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075295 | A. BUILDING _____ B. WING _____ | 11/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILLER MEMORIAL COMMUNITY | 360 BROAD STREET MERIDEN, CT 06450 |



| (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 332 | Continued From page 3<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, clinical record reviews, and interviews for three of ten residents reviewed for medication administration (Resident #23, #27 and #40), the facility failed to ensure that the medication error rate was less than five percent. The findings include:<br><br>1. Resident #23's diagnosis included dementia, and hypothyroidism. A Physician's order dated 9/26/11 directed to administer Synthroid 25mcg daily at 6:00 am. Observation of the medication administration on 11/14/11 at 9:50am with Licensed Practical Nurse (LPN) #2 noted Synthroid 25mcg was removed from the medication blister package to be administered to the resident. Subsequent to surveyor inquiry the Synthroid was removed. Review of the medication administration record dated 11/14/11 identified R #23 had received Synthroid 25mcg at 6:00 am.<br><br>2. Resident #27's diagnosis included hypertension. A physician's order dated 10/11/11 directed to administer Metoprolol Extended Release (ER) 50 mg by mouth once a day and to crush appropriate medications. An observation on 11/15/11 at 9:12 am noted Licensed Practical Nurse (LPN) #1 crushed Metoprolol ER 50mg and administered the medication to the resident. Review of the Metoprolol ER medication labels and interview on 11/15/11 at 10:00 am with LPN #1 indicated she did not see the direction on the medication labels not to crush the medication. LPN #1 further indicated R #27 was unable to swallow whole pills. Interview on 11/16/11 at 8:00 | F 332 | B. The Pain Management Policy will be revised to include the expectation to include physical and/or visual assessments for residents experiencing pain.<br>4. How the facility will monitor its corrective action(s) to ensure that the deficient practice will not recur, (i.e., what quality assurance or other program will be put into place to monitor the continued effectiveness of the systemic change).<br>A. The DNS or designee will randomly monitor charts and documentation of residents who have bruising with pain.<br>B. If any issues with the monitoring will be addressed immediately.<br>C. Results of the random monitoring will be reviewed at the QA Committee meeting and if any recommendations are needed, they will be submitted to the appropriate staff.<br>5. Identify the staff member, by | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075295 | A. BUILDING _____ B. WING _____ | 11/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILLER MEMORIAL COMMUNITY | 360 BROAD STREET MERIDEN, CT 06450 |



| (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 332 | Continued From page 4<br>am with the consultant pharmacist indicated extended release medications should not be crushed. Interview on 11/17/11 at 8:30 am with the Director of Nurses indicated if a resident cannot swallow an extended release medication the physician should be notified.<br><br>3. Resident #40's diagnosis included hypertension. A physician's order dated 10/28/11 directed to administer Metoprolol Extended Release (ER) 100mg by mouth once a day and to crush appropriate medications. An observation on 11/15/11 at 9:20 am noted Licensed Practical Nurse (LPN) #1 crushed Metoprolol ER 100mg and administered the medication to the resident. Review of the Metoprolol ER medication labels and interview on 11/15/11 at 10:00 am with LPN #1 indicated she did not see the direction on the medication labels not to crush the medication. LPN #1 further indicated R #40 was unable to swallow whole pills. Interview on 11/16/11 at 8:00 am with the consultant pharmacist indicated extended release medications should not be crushed. Interview on 11/17/11 at 8:30 am with the Director of Nurses indicated if a resident cannot swallow an extended release medication the physician should be notified.<br><br>Review of facility policy on medication administration indicated licensed staff will read the medication label three times prior to administering, when removing the medication pack from the drawer, before pouring the medication, and after pouring the medication, and will crush medication only after checking with the pharmacy and/or supervisor because medication may be time-release capsules or enteric-coated | F 332 | title, who has been designated the responsibility for monitoring the individual plan of correction for each deficiency and the completion date of each component.<br>D. DNS<br><br>F 332<br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>A. Resident # 23 receives synthroid at 6:00 am.<br>B. Resident #27 & #40 medications were changed on November 15, 2011 to medications that could be crushed.<br>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br>A. All residents with medications that cannot be crushed have the potential to be affected and will not have their medications crushed per pharmacy guidelines.<br>B. All residents who received medications | 12/06/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075295 | A. BUILDING _____ B. WING _____ | 11/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILLER MEMORIAL COMMUNITY | 360 BROAD STREET MERIDEN, CT 06450 |

| (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 332 | Continued From page 5<br>drugs. | F 332 | have the potential to be affected by receiving the wrong medications.<br>3. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and,<br>A. All nursing staff will be re-educated on the medication pass by a pharmacy consultant.<br>B. All licensed staff will be re-educated to Miller Memorial's Medication Administration Policy.<br>4. How the facility will monitor its corrective action(s) to ensure that the deficient practice will not recur, (i.e., what quality assurance or other program will be put into place to monitor the continued effectiveness of the systemic change).<br>A. The DNS or designee will randomly monitor licensed staff's medication administration.<br>B. Any issues with the random monitoring will be addressed immediately.<br>C. Results of the random monitoring will be | |
| F 456 SS=D | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION<br><br>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interview the facility failed to ensure water temperatures were maintained at a safe temperature. The findings include:<br><br>Observation on 11/14/11 at 10:30 am identified the water temperature in the snack nook on the 1st floor was 142 degrees. A second water temperature in the snack nook on the 2nd floor was 140 degrees. Interview with the environmental specialist manager at that time indicated water temperatures are monitored at the boiler site, but not on the resident units. After surveyor inquiry, the temperature thermostat was adjusted. Subsequent observations on 11/14/11 at 11:00 am noted the following temperatures were recorded; shower 2nd floor 107.5 degrees, Caroline Hall shower 106.6 degrees, Edward Pavilion shower 98.9 degrees. Review of the facility domestic water temperature policy indicated water temperatures will be checked weekly. Room selection will be random with a minimum of 20% of the rooms on each unit checked. Resident areas must read between 115 and 120 degrees. | F 456 | | |
| F 492 | 483.75(b) COMPLY WITH | F 492 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075295 | A. BUILDING _____ B. WING _____ | 11/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILLER MEMORIAL COMMUNITY | 360 BROAD STREET MERIDEN, CT 06450 |



| (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 492 SS=D | Continued From page 6<br>FEDERAL/STATE/LOCAL LAWS/PROF STD<br><br>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of facility documentation, clinical record, and interview reviewed for 1 of residents reviewed for injuries of unknown origin (Resident #29), the facility failed to notify the state agency in a timely manner in accordance with Section 19a-13-D8t (g) Reportable event (3) Report. The findings include:<br><br>The Reportable Event dated 8/11/11 identified Resident #136 complained of right hip pain on 8/11/11. The x-ray report dated 8/11/11 identified a right subcapital fracture with slight displacement. The investigation identified the State Agency was not notified until 8/17/11 (7 days later). The facility Reporting to Government Authorities policy identified an event that caused serious injury or a significant change in the resident condition will be reported to the Department of Public Health in writing within 72 hours. Interview and review of the Reportable Event dated 8/11/11 with the Director of Nurses (DNS) on 11/16/11 at 1:45 pm identified the incident was not reported to the State Agency until 8/17/11 due to an oversight. | F 492 | reviewed at the QA Committee Meeting and if any recommendations are needed, they will be submitted to the appropriate staff.<br>5. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction for each deficiency and the completion date of each component.<br>A. DNS<br><br>F 456<br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>A. An immediate Plan of Correction was put into place to monitor water temperatures.<br>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br>B. All residents are at risk to be affected. A new policy was put into place to monitor and record random room water temperatures on a | 12/06/2011 |

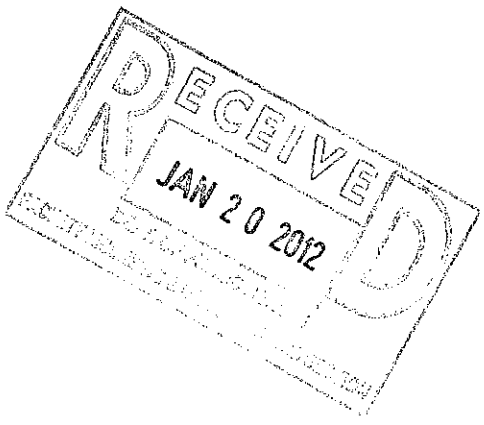
weekly basis.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and,
    A. The Environmental Services Manager will be re-educated to check room water temperatures on a weekly basis.
4. How the facility will monitor its corrective action(s) to ensure that the deficient practice will not recur, (i.e., what quality assurance or other program will be put into place to monitor the continued effectiveness of the systemic change).
    A. The Environmental Services Manager or designee will randomly monitor the random room water temperatures.
    B. Any issues will be addressed immediately.
    C. Results of the random monitoring will be reviewed at the QA Committee Meeting and if any recommendations, they will be submitted to the appropriate staff.

5. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction for each deficiency and the completion date of each component.
    A. Environmental Services Manager 12/06/2011

F 492

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?
    A. Resident #29 will have any reportable events reported to the State Agency in a timely manner as directed by regulation.
2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
    A. All residents with reportable events that require reporting to the State agency are at risk to be affected and will have those reportable events reported in a timely manner.
3. What measures will be put into place or systemic changes



made to ensure that the deficient practice does not recur; and,

A. The DNS and ADNS will be re-educated to the Reporting to Government Authorities Policy.

4. How the facility will monitor its corrective action(s) to ensure that the deficient practice will not recur, (i.e., what quality assurance or other program will be put into place to monitor the continued effectiveness of the systemic change).

A. The Compliance and Quality Assurance Officer will randomly monitor any reportable events that need to be reported to the State Agency for timely reporting.

B. Any issues will be addressed immediately.

C. Results of the random monitoring will be reviewed at the QA Committee Meeting and if any recommendations, they will be submitted to the appropriate staff.

5. Identify the staff member, by title, who has been designated

the responsibility for
monitoring the individual plan
of correction for each
deficiency and the completion
date of each component.

D. DNS 11/15/2011