

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155581	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567
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F 0000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Dates: July 27, 28, 29, 30, 31 and August 3, 2015</p> <p>Facility Number: 000566 Provider Number: 155581 AIM Number: 100267450</p> <p>Census bed type: SNF: 04 SNF/NF: 46 Total: 50</p> <p>Census payor type: Medicare: 10 Medicaid: 30 Other: 10 Total: 50</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)			

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=D Bldg. 00	<p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interviews, the facility failed to ensure 1 of 2 abuse</p>	F 0225	F 225	09/01/2015	

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	<p>allegations reviewed was reported timely. This allegation affected Resident #83.</p> <p>Finding includes:</p> <p>During an interview on 7/28/15 at 9:41 A.M., Resident #83 indicated when she was a resident at the facility for her first admission within the year, a nursing assistant had refused to care for her and had slammed her room door shut. The resident indicated she had reported the allegation of abuse to the nurse and the Social worker.</p> <p>An allegation of abuse involving Resident #83, indicated the allegation had been reported by the Resident on 04/09/15. The facility had investigated the allegation and determined abuse had not occurred. During an interview on 07/30/15 at 9:40 A.M., the Administrator indicated he had not reported the allegation of abuse to the Department of Health and other required entities. The Director of Nursing, also interviewed on 07/30/15 at 9:40 A.M., indicated it was not reported because abuse could not be substantiated.</p> <p>The facility Abuse Prohibition, Reporting, and Investigation policy and procedure, with a start date of 07/15/15, included the following: "...Millers Health</p>		<p>It is the policy of Miller's Merry Manor- Syracuse to investigate/report allegations of abuse to the appropriate agencies to prevent further potential abuse while the investigation is in process. The results of all investigations will be reported to the Administrator or Designee and to other officials in accordance to State Law.</p> <p>Resident #83 did not suffer from nor was affected by any abusive action or intent.</p> <p>All residents residing in the facility have the potential to be affected by this deficient practice.</p> <p>During daily stand up meeting, through review of the 24-hour condition report tool and via reporting by staff to Administration, all allegations of abuse and mistreatment are reported to the proper authorities immediately.</p> <p>The Administrator and Director of Nursing (DON) were re-educated on 08-17-15 on the "Abuse Prohibition, Reporting, and Investigation" (Attachment A) Policy by the Regional VP and QAA Nurse consultant assigned to this facility. Any allegation of abuse or mistreatment will be reported to the Administrator immediately and reported to the state authority at that time via the reporting system</p>	

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	<p>Systems has policies and procedures in place that ensures that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures...." and "...1. All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative (sponsor, responsible party) , as soon as feasibly possible, but no later than within 24 hours of the reporting or discovery of the incident. 2. Violations of the aforementioned will be reported to the Long Term Care Division of the Indiana State Department of Health and other officials in accordance with state law through established procedures as outlined in the "Incident Reporting to the ISDH" procedure...."</p> <p>3.1-28(c)</p>		<p>e-mail. Additionally abuse investigation procedure will be conducted for fact finding and investigation.</p> <p>The Regional VP and/or QAA Nurse will be notified that an allegation has been reported to ensure proper reporting procedure is completed. Follow up with the reportable system will be done as applicable. The 24 hour condition report will be completed daily Monday through Friday for reporting compliance. (Attachment1)</p> <p>Monthly the Administrator will report to the Quality Assessment and Assurance (QAA) Committee the results of reporting, the investigation checklists and any further steps taken to complete thorough investigations. The QA Committee will review the results monthly for 6 months and recommend any further actions necessary in order to ensure that allegations are reported timely and thoroughly investigated.</p> <p>Completion date 09-01-15.</p>	

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F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interviews, the facility failed to implement their Abuse policy and procedure regarding reporting allegations to the Department of Health. This policy failure was noted on 1 of 2 allegations of abuse reviewed.</p> <p>Finding includes:</p> <p>During an interview on 7/28/15 at 9:41 A.M., Resident #83 indicated when she was a resident at the facility for her first admission within the year, a nursing assistant had refused to care for her and had slammed her room door shut. The resident indicated she had reported the allegation of abuse to the nurse and the Social worker.</p> <p>An allegation of abuse involving Resident #83, indicated the allegation had been reported by the Resident on 04/09/15. The facility had investigated the allegation and determined abuse had not occurred. During an interview on</p>	F 0226	<p>F 226 It is policy of Miller's Merry Manor-Syracuse to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property to utilize a system for reporting allegations of abuse to the proper authorities. No residents suffered any negative consequences as a result of this finding. All residents in the facility have the potential to be affected by this finding. The Administrator and Director of Nursing (DON) were re-educated on 08-17-15 on the "Abuse Prohibition, Reporting, and Investigation" (Attachment A) Policy by the Regional VP and QAA Nurse Consultant assigned to this facility to ensure that compliance is maintained. The Regional VP and/or QAA Nurse will be notified that an allegation has been reported to ensure proper reporting procedure is completed. Follow up with the reportable system will be done as applicable. The 24 hour condition report will be completed daily</p>	09/01/2015

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	<p>07/30/15 at 9:40 A.M., the Administrator indicated he had not reported the allegation of abuse to the Department of Health and other required entities. The Director of Nursing, also interviewed on 07/30/15 at 9:40 A.M., indicated it was not reported because abuse could not be substantiated.</p> <p>The facility Abuse Prohibition, Reporting, and Investigation policy and procedure, with a start date of 07/15/15, included the following: "...Millers Health Systems has policies and procedures in place that ensures that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures...." and "...1. All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative (sponsor, responsible party) , as soon as feasibly possible, but no later than within 24 hours of the reporting or discovery of the incident. 2. Violations of the aforementioned will be reported to the Long Term Care Division of the Indiana State Department of Health</p>				<p>Monday through Friday for reporting compliance. (Attachment1)</p> <p>Monthly the Administrator will report to the Quality Assessment and Assurance (QAA) Committee the results of reporting, the investigation checklists and any further steps taken to complete thorough investigations. The QA Committee will review the results monthly for 6 months and recommend any further actions necessary in order to ensure that allegations are reported timely and thoroughly investigated.</p> <p>Completion date 09-01-15.</p>		

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F 0241 SS=D Bldg. 00	<p>and other officials in accordance with state law through established procedures as outlined in the "Incident Reporting to the ISDH" procedure...."</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and record review, the facility failed to ensure an indwelling catheter bag was covered for 1 of 2 residents observed with a catheter. (Resident #98)</p> <p>Findings include:</p> <p>The clinical record for Resident #98 was reviewed on 08/03/15 at 1:30 P.M. Resident #98 was admitted to the facility, on 07/20/15, with diagnoses, including but not limited to, edema, lymphedema, esophageal reflux, hyperlipidemia and hypothyroidism.</p>	F 0241	<p>F241</p> <p>It is policy of Miller's Merry Manor to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Resident #98 was not adversely affected by this finding. Placement of the catheter bag has been corrected to support dignity.</p> <p>All residents, residing in the facility have the potential to be affected by</p>	09/01/2015

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	<p>On 07/28/15 at 1:33 P.M., Resident #98 was seated in a recliner in her room. The resident's urine catheter bag was uncovered and was hanging on the side of the resident's recliner visible from the hallway. At 1:35 P.M., a licensed nurse entered the resident's room to assist the resident to the bedside commode and then back from the commode into her recliner. The catheter bag was still uncovered and positioned hanging on the side of the resident's recliner visible to the hallway.</p> <p>On 08/03/15 at 1:40 P.M., Resident #98 was seated in her recliner in her room. Her uncovered catheter bag was noted hooked to the side of her trash can and was visible to the hallway.</p> <p>The current facility, Foley Catheter Care and Maintenance, policy, start date of 08/03/07, was provided by the Administrator on 08/03/15 at 2:00 P.M. The policy indicated the following: "...E. Placement of Catheter Tubing Procedure. 1. When in bed or wheelchair: ...b. Place in a catheter cover bag underneath wheelchair or on side of bed...."</p> <p>3.1-3(t)</p>		<p>dignity issues.</p> <p>All residents have been reviewed to ensure dignity. This was completed on 8-28-15.</p> <p>To prevent this from reoccurring, the nursing staff will receive education related to resident dignity requirements on 8-7-15 and again on 08-21-15 (Attachment F and G).</p> <p>Daily room rounds will be completed for 2 months by Departmental Personnel as well as assigned staff to ensure that resident dignity is maintained. These rounds will be documented on the QA tool titled "Resident Dignity/ Needs/ Environmental Review." (Attachment 2)</p> <p>Then on a monthly basis, 10% of a random sampling of resident rooms will be audited to ensure that dignity issues are not found and if so addressed immediately with corrective actions. Any identified trends will be corrected and logged and presented at the QAA monthly meeting for review and action plan as warranted.</p> <p>Completion date 09-01-15.</p>				

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F 0248 SS=D Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interviews the facility failed to ensure 2 of 3 dependent residents reviewed for activities were provided with activities to meet their needs. (Resident #39 and #50)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #50 was reviewed on 07/30/15 at 10:22 A.M. Resident #50 was admitted to the facility on 11/02/10 with diagnoses, including but not limited to, Alzheimer's disease, diabetes type II, esophageal reflux otsteoarthrosis, hyperlipidemia and hypertension.</p> <p>The annual Activity assessment, completed on 11/12/14, indicated the resident liked to look at pictures in magazines, liked Elvis's music in the past, liked watching/listening to TV, listening to music in the past, visits with</p>	F 0248	<p>F-248</p> <p>It is policy of Miller's Merry Manor – Syracuse to provide an ongoing program of activities designed to, meet in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident.</p> <p>Residents' # 39 and 50 did not suffer any negative affects from this deficient finding. Both residents are receiving activity interests per care plan.</p> <p>All dependent residents residing in the facility have the potential to be adversely affected by this finding.</p> <p>To prevent this occurring, all dependent residents especially those with dementia or other cognitive impairments will have their care plans and activity plans reviewed to ensure that appropriate</p>	09/01/2015

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	<p>family and in the past enjoyed traveling. The assessment indicated she like watching animal programs, shows with children, and funny shows. The group activities the resident participated in were: sunshine/sensory, van rides, outside when the weather was nice, special programs- birthday parties, special music programs, and music player/radio in room. The assessment indicated the resident was passive and was dependent for staff to take her to and from activities.</p> <p>A quarterly assessment, dated 05/19/15, indicated the resident participated in special programs, music programs, outside programs, and sensory groups in the past quarter. The assessment indicated she was a passive participant. The assessment also indicated the resident liked to listen to music and TV, and visited with family and friends.</p> <p>The activity care plan, last updated on 05/12/14, indicated the resident enjoyed and benefited from increased socialization/stimulation. The goal was for the resident to attend daily activities such as sensory stimulation and socialization. The interventions included: "assist to activities that focus on sensory such as sensory groups for stimulation and socialization, staff to play</p>		<p>activity needs are addressed and implemented. To assist with implementation of in-room/non group activities a system has been developed, to cue staff making certain that music, TV, magazines, reading materials, stuffed animals, etc. are offered to the resident for sensory/cognitive stimulation when not participating at a group activity.</p> <p>Monitoring of this system will be done via the Resident Dignity/ Needs/ Environment Review (Attachment 2) and the Life Enrichment for Cognitively Impaired Residents tool (Attachment 10). This rounding will be completed by designated staff members and reviewed weekly by the Activity Director or assistant and Administrator. Daily monitoring will be completed for 30 days, then weekly for 4 weeks, then monthly thereafter. Corrective actions will be made upon discovery. A summary of the findings will be submitted to the QAA meeting for review and revisions monthly.</p> <p>Completion date 09-01-15</p>	

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	<p>Elvis music/cd while resident in bed, assist to outdoor activities, praise all efforts, assist to/from activities."</p> <p>Resident #50 was not observed to participate in a scheduled activity during the daytime hours on 07/27/15 and 07/28/15.</p> <p>On 07/30/15 at 9:40 A.M., Resident #50 was lying in her bed asleep. There was no music playing in the resident's room.</p> <p>On 07/30/2015 at 10:19 A.M., Resident #50 received incontinence care and was transferred to her wheelchair and placed in the unit lounge area in front of the television. The resident had her eyes closed and was audibly grinding her teeth. She remained in front of the television, which was playing a game show until 11:00 A.M., when she was pushed to the dining room table by a unit manager.</p> <p>On 07/30/15 at 2:39 P.M., Resident #50 was lying in her bed awake, grinding her teeth. There was a CD player in her room but it was not on, was facing the wall and had a light layer of dust on it.</p> <p>On 7/31/15 at 8:15 P.M., Resident #50 was seated in her high back wheelchair in the unit lounge on the opposite side of</p>						

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	<p>the television, grinding her teeth.</p> <p>On 07/31/15 at 8:25 A.M., Resident #50 was taken to her room to be changed and placed in bed. At 9:30 A.M., Resident #50 was in her bed asleep. There was no music playing.</p> <p>On 07/31/15 at 10:00 A.M., Resident #50 was awake in her bed in her room.</p> <p>Resident #50 was placed in her wheelchair and pushed beside the television in the unit lounge on 07/31/2015 at 10:42 A.M. She was pushed to the dining room at 10:43 A.M.</p> <p>Review of the Activity Calendar for July 2015 indicated on Thursday, July 30th, the following activities were scheduled: "10:15 A.M. - Stretch [exercises] in the Main Dining room, 11:00 A.M. Sunshine [sensory stimulation group] in the dining room, 1:30 Activity Cart on all halls, 2:30 Birthday Celebration in the dining room, 5:30 evening games on the Cattail Pod [nursing unit]." The activities scheduled for Friday, July 31 were as follows: "9:30 A.M. Bible Ed in the Cattail unit, 10:15 A.M. Stretch in the Dining room, 11:00 A.M. Sunshine and Fun Food in the Dining room, 1:30 P.M. Activity Cart on all units, 2:15 P.M. Patio time on the Patio, and 3:15 P.M.</p>			

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	<p>Sunshine Club in the Lakeshore Pod."</p> <p>The Activity Participation log for Resident #50 for July 30 and 31, 2015 indicated the resident participated in a Sunshine club activity at the noon meal and the Birthday party on Thursday and two Sensory groups and refreshments on Friday . Interview with the Activity Director, on 08/03/15 at 9:30 A.M., indicated the Sensory groups were held in the dining room at the C-shaped assisted tables, where Resident #50 sat for meals, as the resident's were waiting on their meals. Resident #50 was also documented as having a beauty shop trip on July 30, 2015 in the morning, however, this event was not observed to have occurred. The Activity Director indicated Resident #50 had a CD player in her room, however, the Activity Director was unaware staff were not playing music for the resident.</p> <p>The Levels of Dementia with relation to Activity Participation form, presented on 08/03/15 at 10:30 A.M., indicated for Level 1 the only activity "Note" for this level was 45 minutes right before the meal sensory activity. The types of sensory aspects were listed. There was no other activity instructions listed for Level 1, which was for End Stage Dementia residents who rarely</p>						

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	<p>communicated, fell asleep in their chairs, and "overcame" gravity.</p> <p>There was no plan to involve Resident #50 in daily activities except for the brief before meal sensory groups which occurred twice a day during the week.</p> <p>2. The clinical record for Resident #39 was reviewed on 07/30/15 at 9:45 A.M. Resident #39 was admitted to the facility on 05/08/09 with diagnoses, including but not limited to, dementia with behavioral disturbances, constipation, depressive disorder, anemia, and hypertension.</p> <p>The most recent activity Annual Assessment, completed on 12/08/2014, indicated the resident liked to look at magazines and pictures, liked all types of music, liked watching birds and television, exercise and pets. The assessment indicated the resident had participated in AM stretch, manicures, outside activities and events, special programs and parties, sensory, and music programs and was a passive participant. The assessment indicated the resident had not experienced any changes in her activity participation, continued to need assistance to and from activities.</p> <p>The quarterly activity assessment, dated</p>			

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	<p>4/28/15, indicated the resident participated in special programs, Birthday parties, outside activities when warmer, manicures, reading group, Sensory, and pet visits. The assessment indicated the resident was a passive participant. In addition, the resident enjoyed holding stuffed animals and visits with her family. The assessment indicated there had been no changes in her activity participation.</p> <p>The activity care plan, which had been last updated on 01/30/14, indicated the resident would benefit from increased socialization/stimulation through activity involvement. The goal was to encourage the resident to attend a daily activities for socialization/stimulation. The interventions included "[resident's first name] enjoys at times caring (sic) a baby doll or a stuffed animal about the facility as if she is looking after and /or caring for it, encourage [Resident's name] to participate to the best of her ability in sensory type activities, per family [Resident's name] has always enjoyed being outdoors when the weather is nice out. Assist to activities located outdoors, [Resident's name] enjoys being around animals of all sorts per family. Encouraged to be a part of pet visits when scheduled as a group activity or when volunteers bring in animals,</p>			

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	<p>[Resident's name] enjoys being with groups of people. Some group activities resident enjoys include manicures, birthday celebrations, special music events, pet visits."</p> <p>On 07/30/2015 at 9:36 A.M., Resident #39 was seated in her wheelchair looking through a picture album of pictures of flowers. The resident was turning the pages and actively looking at the pictures.</p> <p>On 07/30/2015 at 10:00 A.M., Resident #39 was taken by staff to her room to take her to the bathroom. She was then placed in the hallway outside of the Beauty shop.</p> <p>On 07/30/2015 at 10:56 A.M., Resident #39 after having her hair fixed was taken to the dining room for lunch. She was placed in a square dining table. At 11:30 A.M., she was not noted to be engaged in any activity in the dining room.</p> <p>On 07/30/15 at 1:12 P.M., Resident #39 was seated in her wheelchair near the television side of the nursing unit, asleep.</p> <p>On 07/30/2015 at 1:44 P.M., Resident #39 was taken to the dining room for ice cream and a Birthday party.</p> <p>On 07/31/15 at 8:05 A.M., Resident #39</p>				

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	<p>was in her room in a recliner sleeping. She was noted to remain in her room, sleeping in her recliner until 11:15 A.M., when she was noted seated at a table in the dining room.</p> <p>On 07/31/15 at 12:45 P.M., Resident #39 was in her wheelchair sleeping in the (name of unit) by the television. She had a red substance all over her mouth.</p> <p>On 07/31/15 at 1:18 P.M., Resident #39 was taken to her room and placed in her bed.</p> <p>The Activity participation logs for Resident #39 for July 30 and 31 indicated the resident had attended the following: three types of activities, music, refreshments, and special events were documented to designate her attendance at the Birthday party, a Sensory stimulation group at the noon meal, and the Beauty shop trip in the morning for Thursday, July 30 and two sensory activities in the dining room at meal times and a refreshment on Friday July 31 at 3:52 P.M. was documented.</p> <p>During an interview on 8/3/15 at 9:30 A.M., the Activity Director indicated the activity entries for Thursday were mostly for Resident #39's attendance at the Birthday party. She indicated Resident</p>			

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F 0279 SS=D Bldg. 00	<p>#39 usually participated in the Sensory groups.</p> <p>There was no plan to involve Resident #39 in daily Activities, except for the brief before meal sensory groups twice a day during the weekdays.</p> <p>3.1-33(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under</p>			

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	<p>§483.10(b)(4). Based on observation, record review and interviews, the facility failed to ensure a care plan was developed to specifically provide interventions to address the resident's needs for staff assistance for dressing, grooming and hygiene needs. This affected 1 of 1 residents reviewed for Activities of Daily Living (ADL) needs. (Resident #37)</p> <p>Finding includes:</p> <p>The clinical record for Resident #37 was reviewed on 07/30/15 at 1:53 P.M. Resident #37 was admitted to the facility, on 04/14/10 and readmitted on 10/31/12, with diagnoses, including but not limited to, senile dementia, hemiplegia affecting dominant side, aphasia, dysphagia and diabetes.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 07/16/15, indicated Resident #37 scored a 1 of 15 on the BIMS (Brief Interview for Mental Status), was severely cognitively impaired, required limited staff assistance for ambulation and transfer needs, required extensive staff assistance for dressing and personal hygiene, and limited staff assistance for toileting needs. The resident was also</p>	F 0279	<p>F-279</p> <p>It is policy of Miller's Merry Manor-Syracuse to develop, review and revise the resident's comprehensive plan of care. It is policy to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>Resident # 39's care plan has been updated to reflect current health status and plan of care and treatment.</p> <p>All residents residing in the facility have the potential to be affected by this finding.</p> <p>To ensure that this deficient practice does not recur, care plan needs for all residents identified as requiring ADL assistance will be reviewed and updated as necessary. In addition utilizing the 24 Condition Report Tool (Attachment 1) with daily staff report, any change in needs will be identified and interventions to plan of care will be made and updated.</p> <p>Monitoring of the effectiveness of the system is done at least weekly through the 24 hour-Condition report audit, which will continue to</p>	09/01/2015

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	<p>documented as having no impairment with her range of motion of both her upper and lower extremities. The resident was documented as always continent of her bowels and bladder.</p> <p>The current health care plan for Resident #37 related to ADL's indicated the resident required limited assistance due to her memory deficit. The interventions were to encourage her to participate in ADL's as much as possible and to keep the physician and family updated with current ADL status thru next care plan meeting.</p> <p>On 07/30/15 at 9:37 A.M., Resident #37 was in her room in her recliner. The room was dark. The room smelled very strongly of urine and it was unclear if the resident was wearing street clothes. She had a white T-shirt type top on and her bottom half was covered with an aphgan.</p> <p>Shower aide, CNA #5 entered resident's room on 07/30/2015 at 10:32 A.M. She woke the resident up to take her for a shower. Resident #37 had no outside pants on, had her brief on sideways, had a visibly soiled shirt on, and wet rubber soled socks on her feet. The CNA got her new clothes to take to the shower room and assisted her to get clean outside pants on to walk to the shower room.</p>		<p>be done weekly and through comprehensive review of MDS assessments for accurate problem identification at time of admission (within 14 days of), quarterly, with significant change and annually. Care Plan Review (Attachment 3) will be completed monthly via the QA audit tools and through the QAA program.</p> <p>Completion date 09-01-15</p>		

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	<p>When queried, CNA #5 indicated the resident was completely independent with her ADL care. There was a pile of wet outside pants and bed clothes noted on the floor of the resident's room.</p> <p>Resident #37 was noted to be sleeping in her room, in her recliner with an aphgan covering her on 07/30/15 at 1:37 A.M. At 2:08 P.M., a therapy aide, Employee # 6 entered her room, woke her up and asked her to come with her for "therapy." The resident was dressed and had her shoes on both feet. Once the resident stood up she indicated to the therapy aide that she needed to use the bathroom. She ambulated with her walker into the bathroom with the assistance of the therapy PTA. She was then assisted to ambulate to the therapy room.</p> <p>On 07/31/15 at 8:15 A.M., Resident #37 was seated in a dining room chair in the main dining room eating her breakfast. She was dressed and her walker was next to her.</p> <p>On 07/31/15 at 9:00 A.M., Resident #37 was in her room in a recliner. She indicated to a CNA she wanted her light turned off. She remained dressed.</p> <p>On 07/31/15 at 10:10 A.M., Resident #37 was seated in her room in a recliner. The</p>			

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	<p>ADON (Assistant Director of Nursing) and unit managers were exiting her room and indicated they had been obtaining a blood sample. The ADON was overheard asking a CAN to change resident's pants as her right pant leg was wet and it appeared she might have spilt her coffee down her leg at breakfast.</p> <p>On 07/31/15 at 10:53 A.M., Resident #37 was seated in her recliner with different pants on and a sweater placed across the front of her upper torso. The resident was wearing gripper socks and her new pants had a golf ball sized wet spot on the right lower pant leg.</p> <p>On 07/31/15 at 11:14 A.M., Resident #37 was in the bathroom in her room with her walker just outside the mostly closed pocket door. The room door was closed to the hallway.</p> <p>On 07/31/15 at 12:45 P.M., Resident #37 was ambulating with her walker in her room back from her bathroom, headed towards her recliner and wardrobe. The resident was naked from the waist down except for her gripper socks.</p> <p>During an interview on 07/31/15 at 12:55 p.m., the Housekeeper, Employee #7 indicated the resident was in her room but was undressed from the waist down.</p>			

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	<p>The housekeeper indicated the resident was "independent" for care needs.</p> <p>During an interview on 07/31/15 at 12:57 P.M., with CNA #8 and 9, who were working on the unit, they both indicated Resident #37 did not require any ADL care assistance unless they heard her "yelling" in her room and then they helped her.</p> <p>On 07/31/15 at 1:00 P.M., Resident #37 was seated in her recliner with her pants off. The door was ajar and the resident was naked from the waist down. An activity assistant knocked on her door and delivered some mail to the resident. The resident had a shirt thrown across the top of her thighs but was still not dressed. There were socks and pants on the floor by the door and a pad and nightgown on the floor by the wardrobe in her room. The resident was heard making verbalizations that kind of sounded like "help" but the exact word was unclear.</p> <p>During an interview on 08/03/15 at 12:38 P.M., RN #10 indicated he thought Resident #37 definitely needed some cues and some limited assistance for her ADL's. He indicated maybe the resident would refuse clothing if she did not like what someone else picked out. He indicated in the mornings he went in and</p>						

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	<p>assisted her to dress but she had picked out her outfits. He was unsure if cues was something that should be care planned.</p> <p>During an interview on 08/03/15 at 1:31 P.M., the MDS coordinator, LPN #11, indicated the resident definitely required limited assistance for ADL's when she would accept it. MDS coordinator indicated she does not always accept assistance. She indicated this morning the resident was in the bathroom without outside pants this morning and she assisted her by handing her outside pants to help her. She indicated the care plans were automatically generated by the corporation computer program and the interventions were very generalized. She indicated the care plan did not describe the care needs of the resident and she did not know why the nursing staff had indicated the resident was completely independent for ADL's.</p> <p>3.1-35(a)</p>			

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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interviews, the facility failed to ensure the care plan regarding anxiety and gastric esophageal reflux disorder were revised to include nonpharmalogical interventions to address the gastric distress which caused the resident anxiety. This affected 1 of 5 residents reviewed for unnecessary medications. (Resident #37)</p> <p>Finding includes:</p> <p>The clinical record for Resident #37 was reviewed on 07/30/15 at 1:53 P.M.</p>	F 0280	<p>F-280</p> <p>It is policy of Miller's Merry Manor-Syracuse to develop a comprehensive assessment and to have the resident participate in the planning care and treatment or changes in care and treatment. To have a care plan developed with in 7 days after the completion of the comprehensive assessment.</p> <p>Resident # 37's care plan has been reviewed to include non-pharmacological and other</p>	09/01/2015
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	<p>Resident #37 was admitted to the facility, on 04/14/10 and readmitted on 10/31/12, with diagnoses, including but not limited to, senile dementia, hemiplegia affecting dominant side, aphasia, dysphasia and diabetes.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 07/16/15, indicated Resident #37 scored a 1 of 15 on the BIMS (Brief Interview for Mental Status), was severely cognitively impaired, required limited staff assistance for ambulation and transfer needs, required extensive staff assistance for dressing and personal hygiene, and limited staff assistance for toileting needs. The resident was also documented as having no impairment with her range of motion of both her upper and lower extremities. The resident was documented as always continent of her bowels and bladder.</p> <p>The current physician's orders for July 2015 for medications included, but were not limited to, the following: Nexium 40 mg (milligrams) bid (a (twice a day) (medication to prevent esophageal reflux) Tums two tablet tid (three times a day) for stomach upset (a medication to treat the discomfort caused by indigestion)</p>		<p>interventions to address anxiety related to GERD symptoms.</p> <p>All residents within the facility have the potential to be affected by this finding. Therefore all residents in house will have a complete review of current care plans completed by 09-01-15.</p> <p>All Staff was In-Serviced on the use of Nonpharmacological interventions prior to the use of any antianxiety medications are administered. This was completed on 8-21-15.</p> <p>To ensure this finding does not recur, any care issues identified through comprehensive assessment will employ both pharmacological and non-pharmacological interventions when applicable. All interventions employed will be reviewed with IDT review done per the MDS schedule, and interventions found effective in-between review will be added as necessary to the care plan. Any orders received on a daily basis are updated to the care plan by the receiving nurse.</p> <p>Monitoring of the effectiveness of this system is done via the QAA program utilizing the Care plan review/audit tool (Attachment 3). This is completed on a monthly basis, but all care plans will be reviewed initially by 09-01-15 and then defer to monthly and quarterly rotation per the QAA program</p>		

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567			
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	<p>Lorazepam (an antianxiety medication) .5 mg one tablet q (every) 6 hour prn (as needed) anxiety Antacid suspension 225- 200 mg/5 ml (milliliter) , 30 ml every 2 hours prn indigestion/stomach upset.</p> <p>The PRN Medication Administration Record (MAR) for the Lorazepam indicated the resident received Lorazepam 14 times in June 2015 and 22 times in July 2015. The interventions for the Anxiety medication did not specifically indicate what physical conditions, environmental changes should be made prior to administering medications. The record indicated the resident was receiving the Lorazepam for Anxiety cause by GERD (Gastro-esophageal Reflux Disorder).</p> <p>The care plan addressing the resident's Anxiolytic (antianxiety medication) use indicated the resident was receiving the medication due to anxiety caused by GERD. The interventions were to administer medications as ordered, monitor for side effects of anxiolytic medication, notify the physician as needed, address physical needs, change environment, and redirect thoughts. The care plan address the resident's Potential for GI (gastrointestinal) upset included interventions to administer medications,</p>		<p>guidelines. Any findings will be/are corrected at time of discovery. Daily review of the 24 hour-Condition Report (Attachment 1) is done daily by the DON/ADON or designated nurse supervisor to ensure that care plans are updated on a daily basis.</p> <p>Completion date 09-01-15</p>				

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	<p>monitor for complaints and notify the MD (physician) as needed, and see nutritional care plan. The nutritional care plan indicated the resident was to be served a regular diet, beverage of choice, be offered a replacements for food if she consumed less than 50 % of a meal, was to select her own menus, was to be assessed for food preferences, was to have her weight ad intake monitored, was to receive vitamin and mineral supplements as ordered, was to be provided with a bedtime snack, have her labs monitored, and the physician was to be notified of a significant weight changes.</p> <p>There was no specific nonpharmalogical interventions to address the resident's GI/GERD distress, other than medications.</p> <p>During an interview on 08/03/15 at 1:30 P.M., the MDS coordinator, LPN #11, indicated the computer automatically generated the care plans.</p> <p>3.1-35(d)(2)(B)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interviews, the facility failed to ensure the care plans for 1 of 1 residents reviewed for incontinence needs (Resident #9) and 1 of 1 residents reviewed for Activities of Daily Living (ADL) needs (Resident #37) were followed.</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #37 was reviewed on 07/30/15 at 1:53 P.M. Resident #37 was admitted to the facility, on 04/14/10 and readmitted on 10/31/12, with diagnoses, including but not limited to senile dementia, hemiplegia affecting dominant side, aphasia, dysphagia and diabetes.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 07/16/15, indicated Resident #37 scored a 1 of 15 on the BIMS (Brief Interview for Mental Status), was severely cognitively</p>	F 0282	<p>F-282</p> <p>It is the policy of this facility that resident care plans are updated with changes in condition, quarterly, annually and with significant change in order to reflect the current resident condition.</p> <p>The care plan for resident # 9 was updated to reflect the current intervention to assist with incontinence needs. Resident #37's care plan has been updated to reflect ADL needs.</p> <p>All residents residing in the facility have the potential to be affected by this finding.</p> <p>To ensure this does not recur, the facility has a system in place that identifies care plan development and review. The system requires care plans be revised as changes in the resident condition dictates. The system ensures that care plans are reviewed and revised as changes occur daily, and a complete review</p>	09/01/2015

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	<p>impaired, required limited staff assistance for ambulation and transfer needs, required extensive staff assistance for dressing and personal hygiene, and limited staff assistance for toileting needs. The resident was also documented as having no impairment with her range of motion of both her upper and lower extremities. The resident was documented as always continent of her bowels and bladder.</p> <p>The current health care plan for Resident #37 related to ADL's indicated the resident required limited assistance due to her memory deficit. The interventions were to encourage her to participate in ADL's as much as possible and to keep the physician and family updated with current ADL status thru next care plan meeting.</p> <p>On 07/30/15 at 9:37 A.M., Resident #37 was in her room in her recliner. The room was dark. The room smelled very strongly of urine and it was unclear if the resident was wearing street clothes. She had a white T-shirt type top on and her bottom half was covered with an aphgan.</p> <p>Shower aide, CNA #5 entered resident's room on 07/30/2015 at 10:32 A.M. She woke the resident up to take her for a shower. Resident #37 had no outside</p>		<p>of care plans and resident status is done at least quarterly. All residents' care plans will be reviewed by 09-01-15 and then through the scheduled care plan process. All staff have been re-educated on the importance of reporting any identified changes in resident status to the Charge nurse/Unit manager so that daily changes in care plan needs may be addressed at that time.</p> <p>Monitoring for accuracy of care plans and compliance with regulations will be done by the MDS Coordinator Monthly using the Care Plan Review Tool (Attachment 3) monthly for 3 months then Quarterly then after. Results will be discussed with the QA team at the monthly meeting.</p> <p>Completion date 09-01-15</p>		

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	<p>pants on, had her brief on sideways, had a visibly soiled shirt on, and wet rubber soled socks on her feet. The CNA got her new clothes to take to the shower room and assisted her to get clean outside pants on to walk to the shower room. When queried, CNA #5 indicated the resident was completely independent with her ADL care. There was a pile of wet outside pants and bed clothes noted on the floor of the resident's room.</p> <p>Resident #37 was sleeping in her room, in her recliner with an aphgan covering her on 07/30/15 at 1:37 A.M. At 2:08 P.M., a therapy aide , Employee # 6 entered her room, woke her up and asked her to come with her for "therapy." The resident was dressed and had her shoes on both feet. Once the resident stood up she indicated to the therapy aide that she needed to use the bathroom. She ambulated with her walker into the bathroom with the assistance of the therapy PTA. She was then assisted to ambulate to the therapy room.</p> <p>On 07/31/15 at 8:15 A.M., Resident #37 was seated in a dining room chair in the main dining room eating her breakfast. She was dressed and her walker was next to her. At 9:00 A.M. Resident #37 was in her room in a recliner. She indicated to a CNA she wanted her light turned off.</p>			

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	<p>She remained dressed.</p> <p>On 07/31/15 at 10:10 A.M., Resident #37 was seated in her room in a recliner. The ADON (Assistant Director of Nursing) and unit managers were exiting her room and indicated they had been obtaining a blood sample. The ADON was overheard asking a CNA to change resident's pants as her right pant leg was wet and it appeared she might have spilt her coffee down her leg at breakfast.</p> <p>On 07/31/15 at 10:53 A.M., Resident #37 was seated in her recliner with different pants on and a sweater placed across the front of her upper torso. The resident was wearing gripper socks and her new pants had a golf ball sized wet spot on the right lower pant leg. At 11:14 A.M., Resident #37 was in the bathroom in her room with her walker just outside the mostly closed pocket door. The room door was closed to the hallway. At 12:45 P.M., Resident #37 was ambulating with her walker in her room back from her bathroom, headed towards her recliner and wardrobe. The resident was naked from the waist down except for her gripper socks.</p> <p>On 07/31/15 at 12:55 P.M., during an interview, the Housekeeper, Employee #7, indicated the resident was in her room</p>			
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	<p>but was undressed from the waist down. The housekeeper indicated the resident was "independent" for care needs.</p> <p>During an interview on 07/31/15 at 12:57 P.M., with CNA #8 and 9, who were working on the unit, they both indicated Resident #37 did not require any ADL care assistance unless they heard her "yelling" in her room and then they helped her.</p> <p>On 07/31/15 at 1:00 P.M., Resident #37 was seated in her recliner with her pants off. The door was ajar and the resident was naked from the waist down. An activity assistant knocked on her door and delivered some mail to the resident. The resident had a shirt thrown across the top of her thighs but was still not dressed. There were socks and pants on the floor by the door and a pad and nightgown on the floor by the wardrobe in her room. The resident was heard making verbalizations that kind of sounded like "help" but the exact word was unclear.</p> <p>During an interview on 08/03/15 at 12:38 P.M., RN #10 indicated he thought Resident #37 definitely needed some cues and some limited assistance for her ADL's. He indicated maybe the resident would refuse clothing if she did not like what someone else picked out. He</p>			

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	<p>indicated in the mornings he went in and assisted her to dress but she had picked out her outfits. He was unsure if cues was something that should be care planned.</p> <p>During an interview on 08/03/15 at 1:31 P.M., MDS coordinator, LPN #11, indicated the resident definitely required limited assistance for ADL's when she would accept it. MDS coordinator indicated she does not always accept assistance. She indicated although staff were verbalizing the resident's independence during the survey, they documented that they had provided limited assistance for Resident #37. She indicated the care plans were automatically generated by the corporation computer program and the interventions were very generalized. She indicated the care plan did not describe the care needs of the resident and she did not know why the nursing staff had indicated the resident was completely independent for ADL's.</p> <p>2. The clinical record for Resident #9 was reviewed on 07/30/15 at 1:27 P.M. Resident #9 was admitted to the facility, on 07/18/12 and readmitted on 04/27/15, with diagnoses, including but not limited to, schizophrenia, dysphagia, chronic airway obstruction, senile dementia and</p>				

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	<p>diabetes.</p> <p>The Bladder Continence Assessment, completed on 04/17/15, indicated the resident was frequently incontinent of her bladder, was not mentally aware of her need to void, was not able to sit on the toilet or commode due to obesity. The assessment indicated the resident received antipsychotic medications and had a history of bladder incontinence prior to admission. There was no documentation of any voiding patterning completed and no indication if the resident was able to participate in a bladder retraining program or if the resident had any toileting program.</p> <p>The current health care plans for Resident #9 included a plan to address the resident's bowel and bladder incontinence. The plan had last been revised on 08/28/12. The goal was for the resident to remain clean, dry and odor free with no signs of skin breakdown. The interventions included assist to toilet before and after meal, HS (bedtime), and prn (as needed), pressure reduction mattress on bed and a pressure reduction cushion in wheelchair, turn and reposition every 2 -3 hours, and weekly skin assessment. The was also a plan to address the resident's persistent positive urine cultures without specific symptoms.</p>			
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	<p>On 7/30/15 at 9:44 A.M., Resident #9 was in her bed awake in her room. At 9:58 A.M., Resident #9 was transferred out of her bed into her wheelchair by staff and the Hoyer lift. She was not toileted or offered a bed pan. She was given incontinence care before being placed in her wheelchair.</p> <p>On 07/30/15 at 1:09 P.M., Resident #9 was lying in her bed awake. At 2:10 P.M., CNA #12 and 13 asked the resident if she wanted to go to the Birthday party. The resident indicated "yes" so CNA #12 and 13 were observed to provide incontinence care and transfer the resident via the Hoyer lift into her wheelchair.</p> <p>During an interview with CNA #12, on 07/30/2015 at 2:23 P.M., she indicated the resident was always just checked and changed (for incontinence needs). She indicated the resident was not placed on the toilet or bedside commode. She indicated her assignment sheet indicated Resident #9 was incontinent and was to be toileted before and after meals. She indicated on some other residents it indicated "check and change" but not on Resident #9's instructions. She indicated she did not know why there was a discrepancy on her assignment sheet.</p>			

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	<p>On 07/31/15 at 8:05 A.M., Resident #9 was in the dining room eating her breakfast. At 8:38 A.M. she was pushed by staff in her wheelchair into her room and placed next to her bed. At 8:44 A.M. she activated her call light and was heard requesting to be placed on a bed pan. During an interview with CNA #14, on 07/31/15 at 8:50 A.M. she indicated Resident #9 routinely requested and utilized a bed pan for continence needs. She indicated she was not placed on a toilet or bedside commode.</p> <p>On 07/31/15 at 12:45 P.M., Resident #9 was seated in her high back wheelchair in the (name of unit) lounge in front of the television. She was then transferred with a Hoyer lift from her wheelchair into bed and was given incontinence care, her wet brief and outside pants were removed and she was left undressed on her bottom half, covered with a blanket. She was not offered a bed pan or offered toileting on a bedside commode which was in the room on her side of the room.</p> <p>Resident #9's care plan was updated on 07/31/15 to address the resident's use of a bed pan.</p> <p>3.1-35(g)(2)</p>			

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F 0315 SS=D Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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 restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interviews, the facility failed to ensure toileting assistance was provided as care planned for 1 of 1 residents reviewed for incontinence needs. (Resident #9)</p> <p>Finding includes:</p> <p>The clinical record for Resident #9 was reviewed on 07/30/15 at 1:27 P.M. Resident #9 was admitted to the facility, on 07/18/12 and readmitted on 04/27/15, with diagnoses, including but not limited to, schizophrenia, dysphasia, chronic airway obstruction, senile dementia and diabetes.</p>	F 0315	<p>F-315</p> <p>It is policy of Miller's Merry Manor Syracuse to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent Urinary Tract Infections and to restore as much normal bladder function as possible.</p> <p>Resident #9 was not adversely affected by this finding and the care plan has been reviewed and updated to address incontinence needs.</p> <p>All residents with incontinence care needs residing in the facility have the potential to be affected by this deficient finding.</p>	09/01/2015

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	<p>The Bladder Continence Assessment, completed on 04/17/15, indicated the resident was frequently incontinent of her bladder, was not mentally aware of her need to void, was not able to sit on the toilet or commode due to obesity. The assessment indicated the resident received antipsychotic medications and had a history of bladder incontinence prior to admission. There was no documentation of any voiding patterning completed and no indication if the resident was able to participate in a bladder retracing program or if the resident had any toileting program.</p> <p>The current health care plans for Resident #9 included a plan to address the resident's bowel and bladder incontinence. The plan had last been revised on 08/28/12. The goal was for the resident to remain clean, dry and odor free with no signs of skin breakdown. The interventions included: assist to toilet before and after meal, hs (bed time), and prn (as needed).</p> <p>On 07/30/15 at 9:44 A.M., Resident #9 was in her bed awake in her room. At 9:58 A.M., Resident #9 was transferred out of her bed into her wheelchair by staff and the Hoyer lift. She was not toileted or offered a bed pan. She was given incontinence care before being</p>		<p>All incontinence care needs have been assessed by facility this was corrected and completed by 8-5-15</p> <p>All residents care plans indicating a degree of incontinence will be reviewed by 09-01-15 and care plan interventions will be updated as necessary to address these needs. These interventions will employ routine toilet and/or incontinence care as indicated upon review. This will be completed upon admission or additionally per the MDS comprehensive assessment schedule, incontinence status is reviewed at least quarterly, with significant change in condition, annually and with any assessed change in incontinence as applicable.</p> <p>Monitoring of this system is completed on a monthly basis per the Care plan review audit via the QAA program using the Bowel and Bladder Incontinence Review (Attachment 4). Review any needs or changes identified are updated at that time. If changes to incontinent needs are found outside of the scheduled review, this information will be addressed and updated by the charge nurse/Unit manager and placed on the care plan for implementation. Findings from the monthly review will be addressed at the QAA meeting monthly, any action plans or changes will be</p>	

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	<p>placed in her wheelchair.</p> <p>On 07/30/15 at 1:09 P.M., Resident #9 was lying in her bed awake. At 2:10 P.M., CNA #12 and 13 asked the resident if she wanted to go to the Birthday party. The resident indicated "yes" so CNA #12 and 13 were observed to provide incontinence care and transfer the resident via the hooyer lift into her wheelchair.</p> <p>During an interview with CNA #12, on 07/30/2015 at 2:23 P.M., she indicated the resident was always just checked and changed (for incontinence needs). She indicated the resident was not placed on the toilet or bedside commode. She indicated her assignment sheet indicated Resident #9 was incontinent and was to be toileted before and after meals. She indicated on some other residents it indicated "check and change" but not on Resident #9's instructions. She indicated she did not know why there was a discrepancy on her assignment sheet.</p> <p>Resident #9 was observed on 07/31/15 at 8:05 A.M. in the dining room eating her breakfast. At 8:38 A.M. she was pushed by staff in her wheelchair into her room and placed next to her bed. At 8:44 A.M. she activated her call light and was heard</p>		<p>implemented at that time.</p> <p>Completion date 09-15-15</p>				

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	<p>requesting to be placed on a bed pan.</p> <p>During an interview on 07/31/15 at 8:50 A.M., CNA #14 indicated Resident #9 routinely requested and utilized a bed pan for continence needs. She indicated she was not placed on a toilet or bedside commode.</p> <p>On 07/31/15 at 12:45 P.M., Resident #9 was seated in her high back wheelchair in the (unit name) lounge in front of the television. She was then transferred with a Hoyer lift from her wheelchair into bed and was given incontinence care, her wet brief and outside pants were removed and she was left undressed on her bottom half, covered with a blanket. She was not offered a bed pan or offered toileting on a bedside commode which was in the room on her side of the room.</p> <p>Resident #9's care plan was updated on 07/31/15 to address the resident's use of a bed pan.</p> <p>3.1-41(a)(2)</p>			

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F 0329 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 record review and interviews, the facility failed to ensure there were adequate indications to support the use of an antipsychotic medication and failed to monitor the side effects of an antipsychotic medication for 1 of 5 resident's review for unnecessary medications. (Resident #14)</p> <p>Finding includes:</p>	F 0329	<p>F-329</p> <p>It is policy of Miller's Merry Manor-Syracuse to keep each resident free of unnecessary drugs.</p> <p>The Social Services Designee has reviewed all monthly medication reviews for accuracy and completed updates as necessary for resident # 14. The medication identified has</p>	09/01/2015

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	<p>On 8/3/15 at 8:53 A.M., a review of the clinical record for Resident #14 was conducted. The record indicated the resident was admitted on 4/12/12 . The resident's diagnoses included but were not limited to: diabetes, hypertension, atrial fibrillation, dementia and depressive disorder.</p> <p>The Medication Administration Record (MAR) indicated the resident was receiving a combination drug which included the following: perphenazine (an antipsychotic) /amitriptyline (an antidepressant) 4/10 milligrams daily for depression.</p> <p>A care plan for depression, dated 11/6/2012, indicated the resident was depressed due to the loss of a home and the loss of independence. The interventions included but were not limited to: give psychotropic medications as ordered, monitor medication side effects at least daily, encourage loved ones to contact/visit, provide support, listen attentively and social service to visit as needed.</p> <p>During an interview, on 8/3/15 at 10:53 A.M., the Social Service Director indicated the facility did not utilize an AIM's (Abnormal Involuntary Movement</p>		<p>been discontinued and the resident has no adverse consequences related.</p> <p>All residents in the facility who receive antipsychotics have the potential to be affected by this deficient finding.</p> <p>To ensure that this does not recur, all residents receiving antipsychotic and/or psychoactive medication will have a drug regimen review and MAR review completed by the Social Services Director or Consultant Pharmacist by 09-01-15. Any identified needs or changes will be addressed at time of discovery as applicable. The Social Service Director and Director of Nursing were reeducated on the policy of antipsychotic monitoring policy on 8-21-15 by Corporate Quality Assurance Nurse. Licensed Nursing staff along with Social Services Director will be In- Serviced by Risk Management Contractor on Monitoring Psychopharmacological Medications. This will be completed on September 4th, 2015.</p> <p>On a monthly basis going forward, all residents receiving psychoactive medications will receive a monthly review and will have a completed QAA audit titled Behavior and Antipsychotic Medication Review (Attachment 5) by the Social Services Designee. Findings will be reviewed with the QAA committee</p>	

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	<p>Scale) test but used a comprehensive side effect monitoring tool when a resident was on an antipsychotic medication. The side effects monitoring was kept on the MAR. The Social Service Director further indicated the resident was currently not being monitored for use of the antipsychotic part of her medication but was being monitored for side effects of an antidepressant. The Social Service Director indicated there was no behavior monitoring completed for the anti-psychotic or anti-depressant medication use.</p> <p>On 8/3/15 at 11:55 A.M., the Director of Social Service provided a policy titled,"Psychotropic Drug Use Policy," dated 6/1/2011, and indicated the policy was the one currently used by the facility. The policy indicated "...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." The policy further indicated with antipsychotic medication use, the resident should be monitored daily for side effects of the medication.</p> <p>During an interview, on 8/3/15 at 1:30 P.M. the family physician indicated he does not use the perphenazine/amitriptyline combination</p>		<p>monthly. Documentation requirements and GDR's will be addressed at this time.</p> <p>Completion date 09-01-15</p>		

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F 0371 SS=F Bldg. 00	<p>medication for any of his other patients. The family physician further indicated the resident was already taking the medication when she first started coming to him and had no reason to be receiving an anti-psychotic medication. The family physician indicated he would be discontinuing the medication.</p> <p>3.1-48(a)(6)</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, record review and interview, the facility failed to ensure staff preparing food applied gloves before touching food and washed their hands during food preparation. This deficient practice potentially affected 48 of 50 residents who ate in the dining room.</p> <p>Finding includes:</p>	F 0371	<p>F 371 Food Procedure, Store/ Prepare/ Serve- Sanitary</p> <p>It is the policy of Miller's Merry Manor Syracuse to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable</p>	09/01/2015

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	<p>On 7/27/15 at 11:14 A.M., Cook #1 indicated she was going to prepare a pureed item. Cook #1 was not observed washing her hands prior to starting the procedure. Cook #1 poured a measured amount of green beans into the food processor. A few of the green beans landed in the middle of the food processor and Cook #1 took her bare hands reached into the food processor and wiped beans down into food processor. Cook #1 then donned gloves and preceded to continue to prepare the green bean puree. Cook #1 removed her gloves and continued to food prep area. Cook #1 started taking food from steamer, removing the wrap and checked the temperatures of the soup, rice gravy and meatballs.</p> <p>On 7/27/15 at 11:35 A.M., Cook #1 took used wrap and papers to the trash can and opened the lid with her bare hands and dropped the items into the trash can. Cook #1 then prepared mobile meals at the steam table. Cook #1 then placed trash in the garbage can and used her hands to open a trash can, instead of the foot pedal. Cook #1 returned to the prep area to check the temperature of foods she had prepared for the noon meal.</p> <p>On 7/27/15 at 11:41 A.M., Cook #1 was</p>		<p>environment to prevent the development and transmission of disease and infection.</p> <p>None of the residents involved in the identified deficient hand washing practice experienced and negative side effects or outcomes.</p> <p>All residents have the potential to be affected by this finding.</p> <p>An all staff In-Service was held 8-7-15 (Attachment G) which included the review of our handwashing procedure. All staff including the staff members identified in the findings was In-Serviced on this policy and procedure. All Dietary Staff Members were re-educated on Kitchen Handwashing Observation, Staff Competency for Proper Glove use, Staff Competency for Handwashing, and Staff Competency for Pureeing Food.</p> <p>To ensure on-going compliance the Infections Control Nurse, Dietary Manager, or Designee will complete the QA tool entitled "Handwashing" with at least 6 randomly picked employees including all meals weekly for 4 weeks, monthly for 3 months then quarterly there after. The Dietary Staff will complete Kitchen Handwashing Observation, Staff Competency for Handwashing Staff Competency for Pureeing Food, and Staff Competency for Proper</p>	

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	<p>observed leaving the kitchen with a plastic container and proceeded to the ice machine, located in the main dining room. Using a scoop, she put the ice into the container and returned to the kitchen and placed the container of ice on a cart. Cook #1 then moved directly to the steam table, removed lids off each food item and placed a serving utensil into each food item. She again left the kitchen and went to a small door, unlatched it and raised the door, which allowed an open area from dining room to kitchen. Cook #1 then returned to the steam table in the kitchen and preceded to dish food items out for the residents noon meal without washing her hands.</p> <p>On 7/30/15 at 9:03 A.M., the Administrator provided a policy titled, "Dietary Manual-Hand Washing," dated 1/30/2013, and indicated the policy was the one currently used by the facility. The policy indicated proper handwashing was the first line of defense in stopping food borne illness outbreaks and staff should wash hands at the following times: "...F. After handling soiled surfaces, equipment or utensils...G. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks...."</p>		Glove Use Monthly for 2 months and Quarterly there after (Attachment 6). Any concerns will be fix immediately and these results will be discussed at the Monthly QA Meeting.				

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F 0441 SS=D Bldg. 00	<p>During an interview, on 7/30/15 at 9:05 A.M., the Administrator indicated the foot pedal was to be used in the food service areas and if an employee used their hands and opened the garbage can with their bare hands, they should wash their hands before touching anything else.</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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>			

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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> <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, record review and interview, the facility failed to ensure tooth brushes were covered, and labeled in 2 of 2 resident bathrooms. (Resident # 53, Resident #8, Resident #65 and Resident #100) . In addition, the facility failed to ensure 4 of 6 staff changed gloves after contamination during peri care. This deficient practice potentially affected 2 of 4 residents for whom incontinence care was observed. (Resident #9 and #50)</p> <p>Findings include:</p> <p>1. On 7/28/15 at 2:15 P.M., two toothbrushes were observed uncovered and unlabeled in Resident #53 and Resident #8's bathroom. One toothbrush</p>	F 0441	<p>F-441</p> <p>It is policy of Miller's Merry Manor Syracuse to 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>It is the intent of this facility to follow infection control police and procedures. Residents' #'s 53, 8, 65, 100, 9, and 50 suffered no negative consequences as a result of this finding.</p> <p>All residents in the facility have the potential to be affected by this finding.</p>	09/01/2015

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	<p>was stored on top of a soap dispenser with brushes against mirror frame and one toothbrush was located behind the sink faucet laying sideways.</p> <p>2. On 8/3/15 at 1:25 P.M., during the environmental tour with the Director of Maintenance (DOM) two toothbrushes were observed lying on same cabinet shelf, unlabeled in Resident # 65 and Resident #100's bathroom. One toothbrush was observed lying on top of hair pins. The DOM indicated the toothbrushes should not be lying on a shelf, unlabeled.</p> <p>3. During the incontinence care for Resident #9, observed on 07/30/15 at 2:19 P.M., CNA #12 and 13 donned gloves, CNA 13 sprayed perineal wash onto dry disposable wipes and wiped the resident's front perineal area. She left the gloves on to assist CNA #12 with putting a clean brief and outside pants on the resident and pulling the resident's pants down. Both CNA's then placed the Hoyer lift pad underneath the resident before CNA #13 removed her gloves and washed her hands.</p> <p>4. Incontinence care for Resident #50</p>		<p>To ensure this does not recur an in-service was held on 08-07-15 (Attachment G) and will be repeated on 08-21-15 (Attachment F) outlining proper glove use, storage of resident personal items, hand washing procedures and incontinence care procedures. All nursing staff will attend these in-services. Housekeeping and environmental personnel will be included in training to ensure that if concerns are found on daily rounds that these events are reported promptly to the Charge nurse for correction i.e. storage of personal items. Staff members involved in the non-compliance issues was individually re-educated. The Resident Dignity/ Needs/ Environment review will be completed two times daily in at least a sampling of 10% of the rooms over the next 30 days to monitor for compliance. This number will complete review for all resident rooms. Monthly a 10% sampling of The Resident Dignity/ Needs/ Environment Review will be completed to monitor for compliance. Then through the QAA program, Rounds review will be completed per program schedule. (Attachments 2, 7, 8)</p> <p>Rounds review corrections will be made at the time of discovery, a summary of compliance and action plan will be presented to the QAA</p>	

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	<p>was observed on 07/28/15 at 1:15 P.M. Resident #50 was transferred via the Hoyer lift by CNA's #5, 16, and 17 from her wheelchair into her bed. CNA #5 and #16 then proceeded to remove the soiled brief from Resident #50. The resident's brief was wet and the resident had some bowel movement in her gluteal fold. CNA #16 sprayed perineal spray on some dry wipes and proceeded to clean the resident's backside. She removed the piece of bowel movement as she cleaned the resident. A clean brief was then positioned underneath the resident Without changing her gloves or washing her hands, CNA #16 then after the resident was rolled onto her back, provided incontinence care to the front of the residents' peri area. After she provided incontinence care to the resident's vaginal area, CNA #16 then removed her contaminated gloves.</p> <p>The Administrator provided the current policy and procedure subject "Peri Care," dated 01/01/2009, on 08/03/15 at 1:30 P.M. The Procedure indicated after removing a soiled brief or pad and wiping off any excess feces, the pad or brief should be placed in a plastic bag. The soiled gloves should be removed and hand washed. After preparing clean water and cloth, apply clean gloves. After cleaning the resident, soiled wash</p>		<p>program monthly for review and revise action plan as needed.</p> <p>Completion date 09-01-15</p>	

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567
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(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 0465 SS=D Bldg. 00	<p>cloths should be placed in a bag. Gloves should then be removed gloves and hands washed.</p> <p>3.1-18(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a clean sanitary bathroom for Resident # 37.</p> <p>Finding includes:</p> <p>On 7/31/15 at 1:50 P.M., Resident # 37 was sitting in a recliner with a brief on and no pants. The resident's toilet had a brown substance on the toilet seat and the front base of toilet had moisture along the seal. A brown substance was noted to the left of the toilet. An uncovered plunger was noted to be sitting on the bathroom floor. The bathroom had an odor to it.</p>	F 0465	<p>F-465</p> <p>It is the Policy of Miller's Merry Manor- Syracuse to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Environmental issues in the bathroom for resident #37 have been corrected. The resident did not suffer any negative effects related to this finding.</p> <p>No other residents in the facility were affected by this finding, and an environmental walk through audit was completed to address any other</p>	09/01/2015

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567		
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	<p>On 7/31/15 at 2:53 P.M., Resident #37's room was observed with the Assistant Director of Nursing (ADON). The ADON observed the toilet plunger in the resident's bathroom, the brown smear on the restroom floor and the moist area around the base of the toilet. The ADON indicated the plunger should not be in the resident's room, it should be kept in the soiled linen room. The Director of Maintenance (DOM) was asked to observe the toilet moisture around the toilet by the ADON. The DOM indicated the toilet moisture was not due to condensation but the toilet had bowel movement and urine on it. The DOM further indicated the plunger should be cleansed after use and covered in plastic.</p> <p>On 8/3/15 at 2:20 P.M., Resident #37's restroom was observed with the DOM. The resident's toilet was observed to have moisture around the base of the toilet. The DOM indicated the moisture was from the resident missing the toilet and the moisture was urine.</p> <p>3.1-19(f)</p>		<p>areas that have the potential to affect other residents.</p> <p>To ensure this does not recur, an in-service will be given on 08-21-15 (Attachment E) with the environmental personnel focusing on the importance of a safe, sanitary and comfortable environment. Daily room rounds will be completed by the Housekeeping or Environmental Service Department Head daily to ensure that the environment is meeting compliance. On the weekend, the Department Manager will do a daily round, monitoring for compliance. Results of these rounds will be documented on the Housekeeping Services Review (Attachment 9).</p> <p>Monitoring of the effectiveness of this system will be done monthly via the Housekeeping Services Review audit tools in the facility.</p> <p>Corrections will be made at time of discovery and findings reported monthly to the QAA committee.</p> <p>Completion date 09-01-15</p>		