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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155039 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>02/24/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>317 BLAIR PIKE<br>PERU, IN 46970 |
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| F 000<br><br>Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 18, 19, 20, 23 and 24, 2015</p> <p>Facility number: 000014<br/>Provider number: 155039<br/>AIM number: 100288670</p> <p>Survey team:<br/>Debora Kammeyer, RN, TC<br/>Winter Hyde, RN<br/>Amy Miller, RN<br/>Lora Swanson, RN<br/>(2/18, 2/19, 2/23, 2/24, 2015)<br/>Julie Wagoner, RN</p> <p>Census bed type:<br/>SNF: 10<br/>SNF/NF: 58<br/>Total: 68</p> <p>Census payor type:<br/>Medicare: 12<br/>Medicaid: 48<br/>Other: 8<br/>Total: 68</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p> | F 000 | The facility requests a paper compliance review of this plan of correction. |  |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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| F 225<br>SS=D<br>Bldg. 00                                | <p>16.2-3.1.</p> <p>Quality Review completed on March 2, 2015, by Brenda Meredith, RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br/>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br/>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</p> |   |   |                      |   |

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|  | <p>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 interview and record review, the facility failed to ensure an allegation of abuse/mistreatment was thoroughly investigated for 1 of 3 abuse allegations reviewed. (Resident # 7)</p> <p>Finding includes:</p> <p>The clinical record for Resident #7 was reviewed on 2/20/15 at 2:10 P.M. Resident #7's significant change Minimum Data Set (MDS) assessment, dated 8/8/14, indicated the resident's BIMS (Brief Interview Mental Status) total score was 14, cognitively intact, indicating the resident was interviewable.</p> <p>Resident #7's allegation of abuse was provided by the Administrator on 2/20/15 at 2:35 P.M. This allegation indicated, on 7/20/14 (time uncertain), the Resident #7 reported that a CNA hurt her arms while transferring her and told the her "if she did not sit down and shut up, her arms would hurt a lot worse."</p> <p>A summary of the "ALLEGATION OF</p> | F 225   | <p>CORRECTIVE ACTION(S) FOR THOSE AFFECTED: According to Brief Interview for Mental Status (BIMS) completed 3/2/15, Resident #7 has severe impairment; therefore, she is not interviewable at this time in regards to the allegation of abuse identified. All residents residing in the facility have the potential to be affected by this deficient practice.</p> <p>CORRECTIVE ACTION(S): Five other residents, who resided at the time of the allegation on the hall where resident #7 resided, were interviewed, in order to determine whether they had been affected by inappropriate behavior of this or any other staff member. These residents reported no mistreatment. The updated summary of the investigation has been signed and dated. MEASURES TO PREVENT RECURRENCE: The Administrator and Director of Nursing (DON) were re-educated on the "Abuse Prohibition, Reporting, and Investigation" Policy. The abuse investigation checklist includes statement(s) from the involved resident(s), results of interviews of other residents, and an investigation</p> | 03/26/2015           |   |

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|  | <p>MISTREATMENT OF (NAME OF THIS RESIDENT) BY (NAME OF EMPLOYEE INVOLVED) 7-20-14," was provided by the DON (Director of Nursing) on 2/20/15 at 3:20 P.M. There was no documentation on the summary related to interviews with the residents.</p> <p>During an interview, on 2/20/15 at 1:54 P.M., the DON indicated Resident #7 was interviewed and she would provide the information.</p> <p>During an interview, on 02/20/2015 at 2:57 P.M., LPN #30 indicated she had talked to the resident's family member, who had not visited for some time. She indicated she had documented the incident, the assessment of Resident #7's physical condition and reported the allegation to her charge staff member.</p> <p>During an interview, on 02/23/2015 at 3:16 P.M., the DON indicated she did not have any further information related to the abuse allegation involving Resident #7.</p> <p>The "Abuse Prohibition, Reporting, and Investigation" policy was provided by the Administrator on 2/20/15 at 8:22 A.M. This current policy indicated the following:<br/>" ...5. RESIDENT ABUSE</p> |   | <p>summary signed and dated by the Administrator or designee. After each investigation is concluded, this checklist will be utilized by the Administrator or designee to review the other's investigation summary, in order to ensure that the investigation included the necessary procedures. Anything lacking in the investigation will be addressed by the Administrator or designee. (Attachment A -- Abuse Investigation Checklist)</p> <p>MONITORING TO PREVENT RECURRENCE: Monthly the Administrator will report to the Quality Assurance (QA) Committee the results of the investigation checklists and any further steps taken to complete thorough investigations. The QA Committee will review the results and recommend any further actions necessary in order to ensure that allegations are thoroughly investigated.</p> |   |  |   |  |

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| F 226<br>SS=D<br>Bldg. 00                                | <p>PROCEDURE: ...J. Residents will be questioned (if alert and competent) about the nature of the incident, and their statement will be put in writing. K. An investigation will be completed to assure other residents have not been affected by the incident or inappropriate behavior and the results documented ...L. The investigation summary compiled by the Administrator or designee may include, but is not limited to: ...A. the summary of the investigation will be signed and dated by the Administrator or designee and will be kept by the facility ...."</p> <p>3.1-28(d)</p> <p>483.13(c)<br/>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br/>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br/>Based on interview and record review, the facility failed to ensure their abuse policy and procedure was implemented regarding the investigation of an allegation of abuse/mistreatment for 1 of 3 abuse allegations reviewed. (Resident # 7)</p> <p>Finding includes:<br/><br/>The clinical record for Resident #7 was</p> | F 226   | <p>CORRECTIVE ACTION(S) FOR THOSE AFFECTED: According to Brief Interview for Mental Status (BIMS) completed 3/2/15, Resident #7 has severe impairment; therefore, she is not interviewable at this time in regards to the allegation of abuse identified. All residents residing in the facility have the potential to be affected by this deficient practice.<br/>CORRECTIVE ACTION(S):</p> | 03/26/2015  |  |   |  |

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|  | <p>reviewed on 2/20/15 at 2:10 P.M. Resident #7's significant change Minimum Data Set (MDS) assessment, dated 8/8/14, indicated the resident's BIMS (Brief Interview Mental Status) total score was 14, cognitively intact, indicating the resident was interviewable.</p> <p>Resident #7's allegation of abuse was provided by the Administrator on 2/20/15 at 2:35 P.M. This allegation indicated, on 7/20/14 (time uncertain), the Resident #7 reported that a CNA hurt her arms while transferring her and told the her "if she did not sit down and shut up, her arms would hurt a lot worse."</p> <p>A summary of the "ALLEGATION OF MISTREATMENT OF (NAME OF THIS RESIDENT) BY (NAME OF EMPLOYEE INVOLVED) 7-20-14," was provided by the DON (Director of Nursing) on 2/20/15 at 3:20 P.M. There was no documentation on the summary related to interviews with the residents.</p> <p>During an interview, on 2/20/15 at 1:54 P.M., the DON indicated Resident #7 was interviewed and she would provide the information.</p> <p>During an interview, on 02/20/2015 at 2:57 P.M., LPN #30 indicated she had talked to the resident's family member,</p> |   | <p>Five other residents, who resided at the time of the allegation on the hall where resident #7 resided, were interviewed, in order to determine whether they had been affected by inappropriate behavior of this or any other staff member. These residents reported no mistreatment. The updated summary of the investigation has been signed and dated. MEASURES TO PREVENT RECURRENCE: The Administrator and Director of Nursing (DON) were re-educated on the "Abuse Prohibition, Reporting, and Investigation" Policy. The abuse investigation checklist includes statement(s) from the involved resident(s), results of interviews of other residents, and an investigation summary signed and dated by the Administrator or designee. After each investigation is concluded, this checklist will be utilized by the Administrator or designee to review the other's investigation summary, in order to ensure that the investigation included the necessary procedures. Anything lacking in the investigation will be addressed by the Administrator or designee. (Attachment A -- Abuse Investigation Checklist) MONITORING TO PREVENT RECURRENCE: Monthly the Administrator will report to the Quality Assurance (QA) Committee the results of the investigation checklists and any further steps taken to complete</p> |   |  |   |  |

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|  | <p>who had not visited for some time. She indicated she had documented the incident, the assessment of Resident #7's physical condition and reported the allegation to her charge staff member.</p> <p>During an interview, on 02/23/2015 at 3:16 P.M., the DON indicated she did not have any further information related to the abuse allegation involving Resident #7.</p> <p>The "Abuse Prohibition, Reporting, and Investigation" policy was provided by the Administrator on 2/20/15 at 8:22 A.M. This current policy indicated the following:<br/>" ...5. RESIDENT ABUSE PROCEDURE: ...J. Residents will be questioned (if alert and competent) about the nature of the incident, and their statement will be put in writing. K. An investigation will be completed to assure other residents have not been affected by the incident or inappropriate behavior and the results documented ...L. The investigation summary compiled by the Administrator or designee may include, but is not limited to: ...A. the summary of the investigation will be signed and dated by the Administrator or designee and will be kept by the facility ...."</p> <p>3.1-28(a)</p> |   | <p>thorough investigations. The QA Committee will review the results and recommend any further actions necessary in order to ensure that allegations are thoroughly investigated.</p> |                      |   |

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| F 242<br>SS=D<br>Bldg. 00                                | <p>483.15(b)<br/>SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, record review and interview the facility failed to ensure the bathing preference regarding tub baths for 2 of 3 residents reviewed for choices was honored. (Resident #15 and Resident #60)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #15 was reviewed on 02/20/15 at 8:30 A.M. Resident #15 was admitted to the facility on 06/09/14, with diagnoses, including but not limited to, edema, diverticulosis of the colon, hypercholesterolemia, anemia, dementia, acute myocardial infarct, syncope, Alzheimer, diabetes mellitus, hypothyroidism, coronary arteriosclerosis, gout, osteoarthritis, and depressive disorder.</p> <p>During an interview, on 02/18/15 at 3:07 P.M., Resident #15's family member</p> | F 242   | <p>Resident's #15 and 60 were affected by the deficient practice regarding Self-Determination related to bathing choice. The facility staff will interview residents #15 and #60 to obtain their bathing preferences. At that time, the Nurse Managers will update the residents' care plans to reflect preferences desired or that options are presented in case preferences vary. Both residents are receiving care per plan of care. All residents in the facility have the potential to be affected by this deficient finding.</p> <p>CORRECTIVE ACTIONS: All residents will be questioned and asked preferences in regards to bathing. Nurse Managers will update the residents' care plans to reflect preferences desired or that options are presented in case preferences vary. (Attachment B - Bathing Preference)</p> <p>MEASURES TO PREVENT RECURRENCE:</p> <p>Nurse managers and the care plan team will be in-serviced regarding the resident's right to make choices</p> | 03/26/2015  |  |   |  |

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|  | <p>indicated the resident preferred to have a tub bath. The family member further indicated the facility staff had been notified of this preference but the resident was still receiving showers instead of baths.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 01/20/15, indicated Resident #15 scored an 8 on her BIMS (brief interview of mental status) which indicated she was moderately cognitively impaired. In addition, the resident required extensive staff assistance for transfers and personal hygiene needs. The resident also required the assistance of one staff for bathing needs.</p> <p>A care plan regarding preferences, initiated on 06/13/14 and last updated on 01/22/15, indicated the resident preferred a bath twice a week. The update regarding a tub bath was made on 01/22/15 to indicate baths as a preference.</p> <p>Review of the "Shower/bath report" form for Resident #15 from January 22, 2015 through 02/22/15, provided by the ADON (Assistant Director of Nursing) on 02/23/15 at 2:00 P.M., indicated she had received 9 showers and 2 full body bed/sponge baths.</p> |   | <p>regarding method of bathing and how to update care plans to reflect resident preferences for bathing.</p> <p>Managers will utilize the interview tool—Bathing Preference — upon admission, with significant change in condition and at least quarterly to identify any changes in residents' bathing preferences.</p> <p>Preferences other than showers will be identified and/or updated on care plans. MONITORING TO PREVENT RECURRENCE: Administrator will review results of QA interview tool monthly in regards to bathing preferences in order to be sure preferences are identified and offered. The Administrator will address any omissions with appropriate nursing managers at that time. The Administrator will report monthly to the QA Committee the results of his reviews and further actions taken. The QA Committee will review the Administrator's report and make any further recommendations necessary in order to ensure that resident bathing preferences are honored.</p> |                      |   |

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|                    | <p>During an interview, 02/24/2015 at 10:30 A.M., RN #25 indicated she was assisting the BNA (Basic Nurse Aide) class in giving showers and baths and the regular shower aide was not working. Review of the current Shower and Weekly Charting list indicated Resident #15 was to receive a shower on Thursdays and Sundays. There was no documentation on the list to indicate the resident desired a tub bath. The Nurse Aide Flow sheet for Resident #15, updated on 02/20/15, did not refer to her bathing preference.</p> <p>2. The clinical record for Resident #60 was reviewed on 02/20/15 at 11:25 A.M. Resident #60 was admitted to the facility, on 04/15/14, with diagnoses, including but not limited to, recent accidental fall, anxiety state, depressive disorder, Parkinson disease, syncope, insomnia, diabetes mellitus, hypertension, hyperlipidemia, and hypertonicity of the bladder.</p> <p>During an interview, conducted on 02/19/15 at 10:32 A.M., with alert and oriented Resident #60, she indicated she preferred a tub bath but did not always receive a tub bath. She indicated "they [nursing staff] do not always have time to give me a tub bath."</p> |               |   |                      |

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| F 244<br>SS=D<br>Bldg. 00 | <p>A care plan for preferences for Resident #60, initiated on 03/19/14 and revised on 12/17/14, indicated there was no bathing preference care planned.</p> <p>The Admission MDS assessment for Resident #60, completed on 03/19/14, indicated the resident indicated it was very important to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>During an interview, conducted on 02/23/2015 at 3:01 P.M., LPN #26, who was responsible for completing MDS assessments, indicated she was not sure who was responsible for care planning preferences.</p> <p>Review of the Shower and Weekly Charting list, updated on 01/25/15, indicated "[Resident's name] takes a tub bath" was typed on the right hand side of the form.</p> <p>Review of the Shower/bath report, for December 2014 through February 22, 2015, indicated Resident #60 indicated she only received a tub bath 4 of the 26 scheduled bathing opportunities.</p> <p>3.1-3(u)(1)<br/>483.15(c)(6)<br/>LISTEN/ACT ON GROUP<br/>GRIEVANCE/RECOMMENDATION</p> |               |   |                      |

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| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>317 BLAIR PIKE<br>PERU, IN 46970 |
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|                    | <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on record review and interviews, the facility failed to act upon concerns/grievances of the Resident Council members concerning staffing issues for 5 of 7 months of Resident Council minutes reviewed. (October through December of 2014, and for January and February of 2015).</p> <p>Finding includes:</p> <p>The Resident Council minutes for October, November, and December of 2014, and for January, and February of 2015 were provided by the Social Service Director on 02/19/2015 at 4:20 P.M. The concerns and facility responses included but were not limited to the following:</p> <p>-On 10/20/2014, the minutes indicated the residents felt there was a shortage of staff and they were not getting showers or put to bed timely. The staff told the residents they could not be of service to them because the residents were not in their "group." The resident council response form, dated 10/28/2014, indicated the AD, (Administrative</p> | F 244         | <p>No residents were adversely affected by this finding. There is sufficient staff on duty to provide care and services to all residents. No residents indicated that they were NOT receiving appropriate care and service due to staffing. All residents residing in the facility have the potential to be affected by this deficient practice.</p> <p>CORRECTIVE ACTION(S):<br/>The Director of Nursing (DON) and other identified Department Heads needing to respond to a concern, will review the Resident Council concerns and will utilize the Response Form to provide a detailed response to the Resident Council's concerns. This response will be reviewed with the resident council president prior to the monthly meeting of the council. The response will be presented to the Resident Council at its monthly meeting scheduled on 3/23/15 and at further Resident Council meetings going forward. The Council President will be made aware that the DON and any other Department Head is available to give further explanation or answer questions, if invited to attend the Council meeting. All Department Managers will be re-educated</p> | 03/26/2015           |

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|  | <p>Director), and DON (Director of Nursing), would routinely review staffing needs. The DON left a note to the CNA's on the group sheet to inform staff to assist residents in need. This included those not necessarily in their group as well.</p> <p>-On 11/17/2014, the minutes indicated the residents would like more nursing staff in the evenings to provide timely care. The resident council response form, dated 11/25/2014, indicated the AD and DON would routinely review staffing needs.</p> <p>-On 12/08/2014, the minutes indicated some residents would like to be made aware of which employee would be assigned to care for them; some were concerned about the number of employees who called in and did not come to work. The resident council response form, dated 11/25/2014 (sic), indicated the DON and Administrator would continue working on making sure resident needs were being met as efficiently as possible. The DON was willing to take a list of names of those specifically experiencing the problem and would address the concerns individually.</p> <p>-On 01/19/2015, the minutes indicated some council members were still concerned about the change in staffing assignment patterns in the evenings. The resident council response form, dated</p> |   | <p>regarding the policy and procedure for Resident Council, including addressing the group's suggestions and concerns through the use of the Resident Council Response Form (Attachment C).<br/>MONITORING TO PREVENT RECURRENCE: Prior to review with the Resident Council, the Resident Council Response Forms will be submitted to the Administrator and Resident council President for review and signature. In the event that the Council President or the Resident Council does not consider the facility's response to be sufficient to address the concern or suggestion, the Administrator will meet with the President and the Department Head in order to determine a sufficient response. The Administrator will report monthly to the QA Committee regarding the responses to the Resident Council concerns and any follow-up actions taken. The QA Committee will review the Administrator's report and make any further recommendations necessary to ensure that sufficient response is given to concerns of the Council.</p> |   |  |   |  |

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|  | <p>01/26/2015, indicated no response to the resident's concern.</p> <p>-On 02/16/2015, the minutes indicated residents continued to think staff were overworked at times, and residents would like showers to take place during the time frames given. The resident council response form, dated 02/20/2015, indicated staff continued doing their jobs as assigned to the best of their ability, and shower aides worked form 9:00 a.m. to 1:00 p.m. and 5:00 p.m. to 8:00 p.m.. If there were no shower aide due to unforeseen event, then, it could be anytime during the day. Everyday was different but staff would do their best to accommodate requests.</p> <p>During an interview, on 02/20/2015 at 10:20 A.M., the Resident Council President, Resident #46, indicated the facility was having staffing problems. She indicated when CNAs called in and did not come to work, the facility would work "short handed," resulting in late or no showers for some residents, and fewer than scheduled bedding changes. She indicated the CNAs told residents they were very busy, so residents did not like to ask for bedding changes or adjustments to the shower schedule to meet their preferences.</p> <p>On 02/24/2015, at 10:43 A.M., the AD</p> |   |   |   |  |   |  |

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| F 279<br>SS=D<br>Bldg. 00 | <p>and DON were interviewed. The AD indicated the facility changed the CNA's shifts from 8 to 12 hours. He indicated he felt the residents perceived they were working with fewer staff. He indicated there was as much staff available whether the CNA's worked 8 or 12 hour shifts. At this same time, the DON indicated that when CNAs call in, they do not work short staffed, but the managers may have worked to keep staffing sufficient.</p> <p>3.1-3(l)</p> <p>483.20(d), 483.20(k)(1)<br/>DEVELOP COMPREHENSIVE CARE PLANS<br/>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 §483.10(b)(4).</p> <p>Based on interviews and record review,</p> | F 279         | CORRECTIVE ACTION(S) FOR  | 03/26/2015           |

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|                    | <p>the facility failed to create a comprehensive care plan to address Activities of Daily Living for 1 of 3 residents reviewed in a sample of three. (Resident #18)</p> <p>Finding includes:</p> <p>On 2/20/15 at 8:28 A.M., a review of the clinical record for Resident #18 was conducted. The record indicated the resident was admitted on 1/7/15. The resident's diagnoses included, but were not limited to: anxiety, insomnia, depressive disorder, coronary atherosclerosis, hypertension, muscle weakness, anemia and diabetes mellitus.</p> <p>The Minimum Data Set (MDS) Admission Assessment, dated 1/19/15, indicated the resident required a one person extensive assist with his personal hygiene needs, which included brushing the resident's teeth.</p> <p>A care plan for Occupational Therapy, initiated 1/28/15, indicated the resident had impaired ability to perform dressing/grooming skills and required increased assistance with basic Activities of Daily Living (ADL).</p> <p>During an interview, on 2/23/15 at 10:10 A.M., the Social Service Director</p> |               | <p>THOSE AFFECTED: The care plan for resident #18's oral care, including assistance needed, preference not to see the dentist, and when and how often oral care is needed. Resident #18 did not suffer any negative outcome related to this finding. Resident #18 has been discharged from the facility. All residents residing in the facility have the potential to be affected by this finding.</p> <p>CORRECTIVE ACTION(S): Nurse Managers will complete an audit of resident care plans, in order to identify those needing assistance with oral care. Nurse Managers will update the care plans, as needed, to address oral care needs. MEASURES TO PREVENT RECURRENCE: Nurse managers will be in-serviced regarding how to develop and update care plans—with each new resident's initial care plan, significant change, and at least quarterly, at the time of each resident care plan review—to include addressing oral care and any other needs as applicable. With the development of each new resident's initial care plan, significant change and at least quarterly, at the time of each resident care plan review, nurse managers will ensure that the care plans include addressing oral care and any other needs as applicable. This will be completed by reviewing the comprehensive</p> |                      |

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|  | <p>indicated the resident had signed a form titled "Patient Choice &amp; Right to Refuse" on admission. The form indicated the resident wanted no on-site services from a dentist.</p> <p>A copy of the complete care plan was received, on 2/23/15 at 10:50 A.M., from the Assistant Director of Nursing (ADON). The care plans did not contain a Dental or ADL care plan to address hygiene needs, such as: assistance the resident needed to complete oral care, the resident's preference to not see the facility's dentist, when oral care would be completed and how often.</p> <p>During an interview, on 2/23/15 at 12:42 P.M., the Director of Nursing (DON) indicated there was no Dental or ADL care plan which included oral care and resident's preference to not see a dentist.</p> <p>On 2/23/15 at 3:00 P.M., the DON provided a current policy titled "Care Plan Development &amp; Review," dated 2/24/14. The policy indicated "1. PURPOSE: To assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment</p> |   | <p>and quarterly assessment information obtained via the Minimum Data Set (MDS) and other associated assessments when indicated.</p> <p>MONITORING TO PREVENT RECURRENCE: Monitoring of this system will be completed at least monthly with care plan review and quarterly by the MDS Coordinator and/or designee prior to or during each resident's care plan scheduled review. Weekly the MDS Coordinator and/or designee will submit the results of her audits to the Director of Nursing, who will direct further action to complete care plan when necessary. (Attachment D - -Care Plan Review) Monthly, the DON will report to the QA Committee the results of the audits and any actions taken. The QA Committee will review the DON's reports and make any further recommendations necessary in order to ensure that care plans address resident needs including oral care.</p> |                      |   |

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| F 280<br>SS=D<br>Bldg. 00                                | <p>process...C. The comprehensive care plan is designed to: I. Address needs, strengths, and preferences that are identified in the comprehensive assessment...."</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2)<br/>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 observation, record review, and interviews, the facility failed to ensure an oral care plan was revised to reflect a resident's current needs and refusal of oral care (Resident #15) for 1 of 3 residents reviewed for activities of daily living needs and failed to ensure a fall care plan was revised for 1 of 3 residents</p> | F 280   | CORRECTIVE ACTION(S) FOR THOSE AFFECTED: Resident #15's care plan has been revised to address the care of dentures and the resident's refusal of oral care. Resident #52's care plan has been revised to address how to maintain the bed at the low position by securing the bed's remote control out of reach of the resident. Resident is not safely | 03/26/2015           |   |

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|  | <p>reviewed for accidents (Resident #52).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #15 was reviewed on 02/20/15 at 8:30 A.M. Resident #15 was admitted to the facility on 06/09/14, with diagnoses, including but not limited to, edema, diverticulosis of the colon, hypercholesterolemia, anemia, dementia, acute myocardial infarct, syncope, Alzheimer, diabetes mellitus, hypothyroidism, coronary arteriosclerosis, gout, osteoarthritis, and depressive disorder.</p> <p>During an interview, conducted on 02/18/15 at 3:18 P.M., Resident #15's family indicated her top dentures were not being cleaned often enough.</p> <p>A quarterly Minimum Data Set (MDS) assessment, completed on 01/20/15, indicated the resident scored an 8 on her BIMS (Brief Interview Mental Status), which indicated the resident was moderately cognitively impaired. Resident #15 also required extensive staff assistance of one staff for transfer and personal hygiene needs.</p> <p>The "Nurse Aide Flowsheet," updated on 02/20/15, indicated "staff to ensure dentures are cleaned daily and put back in</p> |   | <p>able to adjust the bed height due to decreased cognitive safety awareness. All residents residing in the facility have potential to be affected by this deficient practice.</p> <p>CORRECTIVE ACTION(S): Nurse Managers will review all care plans of the residents residing in the facility to ensure that oral care, potential for falls and other needs are identified and included in the care plan.</p> <p>MEASURES TO PREVENT RECURRENCE: Nurse managers will be in-serviced regarding how to develop and update care plans—with each new resident's initial care plan, significant change, and at least quarterly, at the time of each resident care plan review—to include addressing oral care, potential for falls, and any other needs as applicable. With the development of each new resident's initial care plan, significant change and at least quarterly, at the time of each resident care plan review, nurse managers will ensure that the care plans include addressing oral care, potential for falls and any other needs as applicable. This will be completed by reviewing the comprehensive and quarterly assessment information obtained via the MDS and other associated assessments when indicated. (Attachment D --Care Plan Review)</p> <p>MONITORING TO PREVENT</p> |                      |   |

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|  | <p>her mouth."</p> <p>Resident #15 was observed, on 02/20/2015 at 9:00 A.M., dressed and sleeping on top of her made bed. There was a small plastic three drawer shelving unit noted with the top shelf partially pulled open. There was a cup with a covered regular toothbrush, a denture tooth brush, and 4 sheets of denture cleansing tablet noted behind the cup. There was also a tube of denture adhesive noted in the cup. There was no moisture visible on the cup or toothbrush.</p> <p>Resident #15 was observed, on 02/20/2015 at 11:11 A.M., seated in her wheelchair in the dining room. Her front bottom teeth were noted to be missing. The remaining bottom teeth were discolored but did not look unclean. Her top teeth were not visible during conversation.</p> <p>The tooth brush and denture brush were noted, on 02/23/15 at 9:10 A.M., in the plastic 3 drawer unit beside the resident's recliner. The brushes were dry and there was no moisture in the cup holding the toothbrushes.</p> <p>During an interview, conducted on 02/24/2015 at 10:15 A.M., CNA #28 indicated she had assisted Resident #15</p> |   | <p>RECURRENCE: Monitoring of this system will be completed at least monthly with care plan review and quarterly by the MDS Coordinator and/or designee prior to or during each resident's care plan scheduled review. Weekly the MDS Coordinator and or designee will submit the results of her audits to the Director of Nursing, who will direct further action to complete care plan when necessary. Monthly, the DON will report to the QA Committee the results of the audits and any actions taken. The QA Committee will review the DON's reports and make any further recommendations necessary in order to ensure that care plans address resident needs including oral care and potential for falls.</p> |                      |   |

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|                    | <p>with her morning care. She indicated the resident had not received oral care because she refused oral care. She indicated she would chart in the POC (plan of care) electronic charting. She showed the charting for Resident #15 and the POC documentation combined oral care with AM/PM care. CNA #28 indicated there was no where to mark refusing for the oral care but she was also to inform the nurse of any refusals of care.</p> <p>During an interview, conducted on 02/24/2015 at 10:23 A.M., LPN #29 indicated she had frequently been notified of Resident #15's refusal of oral care and/or refusing to remove her dentures so they could be cleaned. She indicated she attempted to get the resident to cooperate with her for oral care but was not always successful. She indicated she assumed the CNAs had somewhere on POC to chart refusals. She indicated she did not routinely document Resident #15's frequent refusals of oral care.</p> <p>The health care plans for Resident #15 regarding assistance with activities of daily living (ADLs), initiated on 06/13/14 and revised on 12/16/14, indicated the resident required extensive staff assistance for ADLs. In addition, a care plan regarding dental needs, initiated on</p> |               |   |                      |

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| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>317 BLAIR PIKE<br>PERU, IN 46970 |
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|                    | <p>06/13/14 and reviewed on 12/16/14 indicated the resident had a potential for oral/dental problems related to missing teeth. The interventions included encouraging oral care twice a day and assistance as needed, and providing the supplies for oral care. There was no mention of the resident's dentures and no instructions regarding what to do when the resident refused oral care or any ADL care.</p> <p>2. On 02/19/2015 at 9:00 A.M., Resident #52 was observed in bed. The bed was observed elevated in the highest position. No staff or family were in the room to monitor the resident. At 9:05 A.M., CNA #5 walked by the resident's room and was observed to enter the resident's room to adjust the bed to the low position.</p> <p>On 02/20/2015 at 8:27 A.M., a review of the clinical record for Resident #52 was conducted. The diagnoses included, but were not limited to: anemia, atrial fibrillation, pneumonia, urinary tract infection, CVA (cerebrovascular accident), depression, edema, unspecified retention of urine, esophagitis, insomnia, hyperplasia of prostate, and dysphagia.</p> <p>The MDS (Minimum Data Set) Quarterly Assessment, dated 11/19/2014, indicated the resident was not able to complete the BIMS (Brief Interview for Mental</p> |               |   |                      |

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|                    | <p>Status), and the functional status of the resident required extensive assistance for ADLs (activities of daily living).</p> <p>A physician's order, dated 9/1/14, was for a low bed with mat, on floor for safety and the bed placed in low position when the resident was in the bed.</p> <p>The care plan, revised on 01/28/2015, indicated the resident was a fall risk due to a history of falls. The care plan further indicated, on 12/22/2014, the resident was found laying the on the mat beside bed. The resident's bed was found in the high position with the remote in his hand. The new interventions included but were not limited to, to the keep bed in the lowest position.</p> <p>During an interview, on 02/23/2015 at 1:37 P.M., RN #12 indicated the bed control was to be kept under the mattress to keep the resident from controlling the bed height. RN #12 indicated the resident's care plan did not specify that the bed control should be kept under the mattress.</p> <p>During an interview, on 02/24/2015 at 1:06 P.M., CNA #5 indicated she had found the resident elevated in his bed on 02/19/2015 at 9:05 A.M. She indicated when she went into the room to lower the</p> |               |   |                      |

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| F 282<br>SS=D<br>Bldg. 00 | <p>bed, she had found the bed control within reach of the resident. CNA #5 indicated the staff was to keep the bed controller under the concave mattress out of the residents reach.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii)<br/>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br/>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 follow a care plan regarding fall prevention for 1 of 3 residents reviewed for accidents. (Resident #15)</p> <p>Finding includes:</p> <p>The clinical record for Resident #15 was reviewed on 02/20/15 at 8:30 A.M. Resident #15 was admitted to the facility on 06/09/14, with diagnoses, including but not limited to, edema, diverticulosis of the colon, hypercholesterolemia, anemia, dementia, acute myocardial infarct, syncope, Alzheimer, diabetes mellitus, hypothyroidism, coronary arteriosclerosis, gout, osteoarthritis, and depressive disorder.</p> | F 282         | <p>CORRECTIVE ACTION(S) FOR THOSE AFFECTED: The Nurse Aide flow sheet for resident #15 has been updated with the instruction to keep resident in the common area until placing her in bed or recliner. The resident's family member who is the Health Care Representative allowed to make decisions for the resident, has declined to allow the resident's walker to be removed from beside her recliner. This action was discussed with the responsible party and removing the walker from beside the resident's chair would contribute to increased anxiety for the resident. All residents residing in the facility have the potential to be affected by this deficient practice. CORRECTIVE ACTION(S): The Nurse Managers will audit all Nurse Aide Flow Sheets (NAFSs) and update them as needed, in order to</p> | 03/26/2015           |

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|                    | <p>A quarterly Minimum Data Set (MDS) assessment, completed on 01/20/15, indicated Resident 15 scored an 8 on her Brief Interview Mental Status (BIMS) indicating moderately cognitively impaired. Resident #15 required extensive staff assistance of one staff for transferring needs, and limited assistance of one for ambulation and locomotion needs, and extensive assistance of one staff for toileting and personal hygiene needs.</p> <p>A fall risk assessment, completed on 06/10/14, indicated the resident had a history of falls, exhibited confusion and forgetfulness and weakness, used an assistive device for mobility, and received a diuretic medication. The assessment indicated the resident was at a low risk for falls.</p> <p>An initial occurrence assessment, completed on 02/10/15 at 2:10 P.M., indicated the resident fell in her room. The assessment indicated she was attempting to transfer herself to her bed. She received a bruise to her right arm. Neurological checks and follow up assessments were conducted and the only injury was the bruise to her right arm.</p> <p>The current health care plan related to falls, initiated on 06/10/14 and revised on</p> |               | <p>ensure that all residents' specific needs noted on the care plan in areas of care performance are indicated on these sheets, including the potential for falls.</p> <p>MEASURES TO PREVENT RECURRENCE: Nurse managers will be in-serviced regarding how to audit and update NAFSSs in order to reflect care plan interventions for performing resident care, including interventions addressing the potential for falls. Whenever care plan interventions are updated with changes in resident care needs, Nurse Managers will update the NAFSSs accordingly. Upon completion of the care plan, the Director of Nursing or Nurse Managers will update the NAFSSs as applicable. MONITORING TO PREVENT RECURRENCE: The DON will audit the NAFSSs weekly for four (4) weeks and then monthly and as necessary to ensure that all appropriate entries are identified in relation to resident care needs. The DON will report monthly to the QA Committee the results of audits of the NAFSSs and actions taken. The QA Committee will review the results of the DON's audits and make any further recommendations necessary in order to ensure that care plan interventions for fall prevention are communicated on the NAFSSs.</p> |                      |

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|  | <p>02/10/15, included the following interventions: 1/2 side rails to bed to provide assist with mobility and positioning, call light in reach, encourage and assist with wearing non-skid footwear, place resident in common area until layed down by staff, reinforce need to call for assistance. The intervention to keep resident in a common area until layed down by staff was added on 02/10/15.</p> <p>The current Nurse Aide Flow Sheet for Resident #15, which had been updated as of 02/20/15, indicated she was a fall risk, was to be toileted before and after meals and activities, was to be encouraged to ambulate to and from the bathroom with staff assistance, and was to be encouraged to keep her legs elevated, but there was no instructions to keep the resident in a common area until she was layed down.</p> <p>Resident #15 was observed, on 02/18/15 and 02/19/15, to spend the morning hours seated in a recliner in her room with the feet elevated. There was no chair alarm noted.</p> <p>Resident #15 was observed, on 02/20/2015 at 1:17 P.M., in her room, sleeping in a recliner next to her bed, with her feet elevated. There was no</p> |   |   |                      |   |

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| F 311<br>SS=D<br>Bldg. 00 | <p>alarm on her recliner.</p> <p>Resident #15 was observed, on 02/20/2015 at 2:12 P.M., sleeping in her recliner.</p> <p>Resident #15 was observed, on 02/23/2015 at 1:19 P.M., sleeping in her recliner with her feet elevated. There was no seating alarm noted. Her walker was located beside her recliner, near her feet and it had a sign on it that said "Please keep [resident's name's] walker in her room."</p> <p>On 02/24/15 at 9:30 A.M., Resident #15 was observed in her room in her recliner with her feet up yelling for help because she needed to get up out of her chair. The chair controller had fallen on the floor and the resident's call light was on her nightstand and not visible. CNA #27, who was working in the hallway, indicated Resident #15 was not supposed to get up by herself and that was the only fall precaution. She was not aware of any other fall precaution.</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(2)<br/>TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS<br/>A resident is given the appropriate treatment and services to maintain or improve his or</p> |               |   |                      |

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|  | <p>her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observations, interviews and record review, the facility failed to provide Activities of Daily Living (ADL) assistance in regards to oral care for 1 of 2 residents reviewed for dental status. (Resident #18)</p> <p>Finding includes:</p> <p>During an interview, on 2/18/15 at 1:15 P.M., Resident #18 indicated he couldn't brush his own teeth and staff never cleaned or brushed them for him. The resident was observed to have broken, missing teeth and a white substance between teeth and near the gum line.</p> <p>During an interview, on 2/20/15 at 11:15 A.M., Resident #18 indicated no one had brushed his teeth during his morning care. The resident's lower teeth were observed to have white debris between his teeth.</p> <p>On 2/20/15 at 8:20 A.M., the resident's bathroom, cabinets, and bedside table were observed for a toothbrush or toothpaste. A toothbrush and toothpaste were not located in the resident's room.</p> <p>On 2/20/15 at 8:38 A.M., Certified Nursing Assistant (CNA) #14 entered the</p> | F 311   | <p>CORRECTIVE ACTION(S) FOR THOSE AFFECTED: Plan of care was developed to address resident #18's oral care during the survey, to include assistance needed, preference not to see the dentist, and when and how often oral care is to be completed. Resident #18 has been discharged from the facility. All residents residing in the facility have the potential for be affected by this deficient practice.</p> <p>CORRECTIVE ACTION(S): All resident care plans will be updated to identify resident needs including oral care related to activities of daily living (ADL) assist. MEASURES TO PREVENT RECURRENCE: Nurse managers will be in-serviced regarding how to develop and update care plans—with each new resident's initial care plan, significant change, and at least quarterly, at the time of each resident care plan review—to include addressing oral care and any other needs related to ADL assist. All care plans are developed based upon a comprehensive assessment at the time of admission, with significant change and at least quarterly. In the same time frame all needs and interventions are developed or updated as necessary. Specific tasks assigned in the Electronic</p> | 03/26/2015  |  |   |  |

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|  | <p>resident's room and was asked to locate the resident's toothbrush and toothpaste. CNA #14 indicated the night nurse completed his care this morning and maybe she threw the toothbrush away, the staff clean the emesis basins and replace the toothbrushes weekly.</p> <p>On 2/20/15 at 8:40 A.M., a review of the clinical record for Resident #18 was conducted. The record indicated the resident was admitted on 1/7/15. The resident's diagnoses included, but were not limited to: anxiety, insomnia, depressive disorder, coronary atherosclerosis, hypertension, muscle weakness, anemia and diabetes mellitus.</p> <p>A careplan for Occupational Therapy, initiated 1/28/15, indicated the resident had impaired ability to perform dressing/grooming skills and required increased assistance with basic Activities of Daily Living (ADL). There was no care plan for ADL's to address hygiene needs and assistance needed with ADL's.</p> <p>The Minimum Data Set (MDS) Admission Assessment, dated 1/19/15, indicated the resident required one person, extensive assist with his personal hygiene needs, which included brushing the resident's teeth. The resident scored a 12 on the Brief Interview Mental Status</p> |   | <p>Medical Record (EMR) are to be completed by nursing staff and other identified personnel. Completion of these tasks is documented either per shift or per day or per assigned time frame. This documentation is contained in the EMR. (Attachment E--Shower/bath report, including oral care) MONITORING TO PREVENT RECURRENCE: On a weekly basis the DON, ADON, Nurse Managers and/or MDS Coordinator will review this documentation utilizing the "Look Back Report" tool contained in the EMR program. Any areas found to be deficient will be corrected as applicable Results of the weekly audit will be reviewed by the DON weekly times 4 weeks and then monthly. Corrections and actions will be made as applicable. Monthly, the DON will report to the QA Committee the results of the audits and any actions taken. The QA Committee will review the DON's reports and make any further recommendations necessary in order to ensure that care plans address assistance with oral care for those residents who need it.</p> |   |  |   |  |

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|                    | <p>(BIMS). The BIMS score indicated the resident was cognitively intact.</p> <p>On 2/23/15 at 9:20 A.M., Resident #18's teeth were observed to have a white substance between his lower front teeth. The resident's toothbrush and toothpaste were located on the counter in his bathroom. The toothbrush was dry as well as the counter it was lying on.</p> <p>During an interview, on 2/23/15 at 9:20 A.M., CNA #5 indicated she had completed the morning care for Resident #18 around 5:30 this morning. CNA #5 further indicated the tooth brush was dry because the rooms are dry, and the resident's debris on his teeth was from breakfast. While the CNA was still in the room the resident was asked if his teeth were brushed this morning and the resident said "no."</p> <p>During an interview, on 2/23/15 at 12:42 P.M., the Director of Nursing (DON) indicated there was no Dental or ADL careplan which included oral care and the resident's preference to not see a dentist. She further indicated there was no policy or procedure indicating the CNA's were to throw toothbrushes away weekly.</p> <p>On 2/23/15 at 1245 P.M., the DON provided a current policies related to Oral</p> |               |   |                      |

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| F 356<br>SS=C<br>Bldg. 00                                | <p>Hygiene, The policy titled, "Morning Care," dated 3/13/15, indicated "...4. Provide oral care by providing mouth care with toothbrush and toothpaste or oral swab and mouthwash..." The policy titled, "Bed Time Care," dated 1/1/15, indicated "...E. Assist resident with oral hygiene..."</p> <p>3.1-38(b)(1)</p> <p>483.30(e)<br/>POSTED NURSE STAFFING INFORMATION<br/>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available</p> |   |   |   |  |   |  |

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|  | <p>to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure the posted staffing was accurate regarding the correct number of Certified Nursing Assistant's (CNA's) working for 2 of 5 survey days. (2/18/15 and 2/20/15)</p> <p>Finding includes:</p> <p>On 2/18/15 at 9:45 A.M., a form posted in the main dining, titled "Daily Nurse Staffing Form," dated 2/18/15, indicated the day shift, from 5:00 A.M. to 5:00 P.M., had 13 CNA's scheduled to work.</p> <p>On 2/18/15 at 9:55 A.M., during the initial tour there was a total of 6 Certified Nursing Assistants (CNA's) observed working throughout the facility. The CNA's were as follows: CNA #4 and CNA # 2 were on the West Unit, CNA #5 was on the South Unit, CNA #6 and CNA#7 were on the Southwest Unit, and CNA #8 was on the Boulevard Unit.</p> <p>On 2/18/15 at 11:00 A.M., a form titled "Dayshift Aide Schedule Second Half of February Year 2015" indicated the</p> | F 356   | <p>CORRECTIVE ACTION(S) FOR THOSE AFFECTED: The Assistant Director of Nursing (ADON) corrected the nurse staffing information posted on 2/20/15, in order to accurately reflect the number of Licensed Nurses and CNAs working each shift in the 24-hour period.</p> <p>CORRECTIVE ACTION(S): The Posted Nursing Staffing remained accurate during the remaining survey days and remains accurate to date.</p> <p>MEASURES TO PREVENT RECURRENCE: The ADON and the nurse designees will be re-educated on the facility policy for "Posting of Daily Nurse Staffing Information," including the necessity that the information be accurate and reflect staffing changes at the start of each shift. (Attachment F -- Daily Nurse Staffing Form) MONITORING TO PREVENT RECURRENCE: The Administrator or designee will inspect the "Daily Nursing Staffing Form" weekly for four (4) weeks, then monthly, in order to ensure that the form is accurate and is being updated, as needed, to reflect staffing changes at the start of each shift. The Administrator will give further</p> | 03/26/2015  |  |   |  |

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|                    | <p>following CNA's were scheduled to work on 2/18/15: CNA's #4, #2, #5, #6, #7, #8 and #9 (a total of 7 CNA's working). CNA #9 started her shift at 11:00 A.M. In addition CNA #10 scheduled to work did not show up and CNA #11 called in (not coming into work).</p> <p>On 2/20/15 at 11:10 A.M., a form titled "Daily Nurse Staffing Form," dated 2/20/15, indicated the day shift, from 5:00 A.M. to 5:00 P.M., had 13 CNA's scheduled to work.</p> <p>On 2/20/15 at 11:15 A.M., the following CNA's were working in the facility: CNA #4, CNA #5, CNA #6, CNA #9 CNA #13, CNA #14, and CNA #15 (a total of 7 CNA's). Six of the 7 CNA's would be ending their shift at 1:00 P.M.</p> <p>During an interview, on 2/20/15 at 1:50 P.M., the Assistant Director of Nursing (ADON) indicated a night nurse completed the Daily Nurse Staffing Form. The ADON indicated the posting was incorrect on 2/18/15 and 2/20/15.</p> <p>On 2/23/15 at 3:20 P.M., the DON (Director of Nursing) provided a current policy titled "Posting of Daily Nurse Staffing," dated 12-6-13. The policy indicated "2. B. The form will include...IV. Total number of registered</p> |               | <p>instruction to the ADON and nurse designees as needed. The Administrator will report monthly to the QA Committee regarding findings from inspections of the Daily Nursing Staffing Form and any actions taken. The QA Committee will review the Administrator's report and make any further recommendations necessary to ensure that the nurse staffing information is posted accurately and updated timely.</p> |                      |

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| F 412<br>SS=D<br>Bldg. 00 | <p>nurses, licensed practical nurses and certified nursing assistants scheduled to work on each shift... C. Any staffing changes made for the day after the form is posted, will be reflected on the form itself..."</p> <p>483.55(b)<br/>ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure routine dental care needs were provided for 1 of 2 residents reviewed for dental needs in a potential sample of 35 who met the criteria for dental needs.<br/>(Resident #60)</p> <p>Finding includes:</p> <p>The clinical record for Resident #60 was reviewed on 02/20/15 at 11:25 A.M. Resident #60 was admitted to the facility, on 04/15/14, with diagnoses, including but not limited to, recent accidental fall,</p> | F 412         | <p>CORRECTIVE ACTION(S) FOR THOSE AFFECTED: On 2/23/15, resident #60 was added to the dental services list for 3/12/15. The resident was seen by the dentist on 3/12/15 in order to address her dental needs. All residents residing in the facility have the potential to be affected by this deficient practice.</p> <p>CORRECTIVE ACTION(S):<br/>Dental Services are provided monthly in the facility. Residents are assigned for routine exam or visit on a rotating basis dependent upon last visit time and/or need. Prior to monthly visit, any resident requiring dental services that are not of an</p> | 03/26/2015           |

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|                    | <p>anxiety state, depressive disorder, Parkinson disease, syncope, insomnia, diabetes mellitus, hypertension, hyperlipidemia and hypertonicity of the bladder.</p> <p>During an interview, conducted on 02/19/2015 at 10:44 A.M., alert and oriented Resident #60 indicated she was having problems with her dentures. She indicated both her top and lower dentures were loose and she had trouble chewing. She indicated in the past she had her dentures realigned, but she was hoping she could get a new pair that fit better. As she spoke Resident #60's top and lower dentures were noted to visibly move out of position and the resident had to frequently readjust them with her lips and hand.</p> <p>During an interview conducted on 02/24/15 at 9:30 A.M., Resident #60 indicated when she was at a hospital in Logansport, the staff there had scraped the realignment material out from her upper dentures.</p> <p>A dental consult, dated 9/30/14, indicated the resident was examined, had upper and lower denture and it indicated the patient would like her lower dentures realigned. The note indicated they were sending it to "Powk" (sic).</p> |               | <p>emergent basis are placed on the list to be seen by the licensed dentist. Any emergent service required is provided at that time in coordination with the resident's attending physician or dentist and/or with an outside provider. An in-house list is maintained by the ADON indicating scheduled visit times to ensure that visits are not missed or overlooked. Any time there is a newly admitted resident or a resident need, this resident is placed on the visit schedule in order to receive a dental visit at the next available time. The current list has been reviewed and all residents' dental schedules are current. PrimeSource (contracted service) also maintains a copy of the resident scheduled visit times. MEASURES TO PREVENT RECURRENCE: At least quarterly, per schedule of care plan meetings, the MDS Coordinator and/or designee will audit each resident's chart for evidence of routine and/or emergency dental services obtained. A paper document of this visit is maintained in the hard copy chart for the review. Upon identification of a resident who has not received dental services needed, the MDS Coordinator and/or designee will request the charge nurse to arrange for dental services. Weekly the MDS Coordinator and/or designee will report the results of her audits to the DON, who will</p> |                      |

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| F 441<br>SS=E  | <p>A social service assessment, completed on 12/17/14, indicated the resident complained she was having trouble keeping her top dentures in her mouth. She requested to be seen and staff were to put her on the "list" next month.</p> <p>During an interview, conducted on 02/23/2015 at 1:37 P.M., the Assistant Director of Nursing (ADON) indicated Resident #60 was not on the January dental list.</p> <p>During an interview, conducted on 02/23/15 at 4:45 P.M., the ADON indicated on September 3, 2014, the resident complained to the dentist about her upper dentures. The upper dentures were realigned on September 30, 2014. She then complained about her lower dentures not fitting. The dentist office was supposed to send the paperwork to have her lower dentures realigned but they forgot to do this and add her to the list to be seen the following visit. The ADON indicated Resident #60 had now been added to the March 2015 dental list.</p> <p>3.1-24(a)(3)</p> |   | <p>direct any further action necessary to obtain dental services. (Attachment G – Dental Services Review)<br/>MONITORING TO PREVENT RECURRENCE: Monthly, the DON will report to the QA Committee the results of the audits and any actions taken. The QA Committee will review the DON's reports and make any further recommendations necessary in order to ensure that routine and emergency dental services are obtained for residents by the facility.</p> |                      |   |
|  | 483.65<br>INFECTION CONTROL, PREVENT   |   |   |                      |   |

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| Bldg. 00           | <p><b>SPREAD, LINENS</b></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<br/>The facility must establish an Infection Control Program under which it -<br/>(1) Investigates, controls, and prevents infections in the facility;<br/>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br/>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(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.<br/>(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<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p> | F 441         | CORRECTIVE ACTION(S) FOR THOSE AFFECTED: Resident #17 was not identified on the Sample Resident List provided to | 03/26/2015           |

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|  | <p>infection control practices were followed during linen handling for 4 of 7 observations of linen handling. (Resident #'s 20, 56, 17, 12 and 73) (CNA #1, CNA #2, and Housekeeper #3)</p> <p>Findings include:</p> <p>On 2/18/15 at 9:55 A.M., during the initial tour of the West Hall Housekeeper #3 was observed carrying resident's personal linens on hangers under her arm next to her uniform for Resident # 20. Housekeeper #3 was observed carrying personal linens using this techniques for Resident #56 and for Resident #73.</p> <p>On 2/18/2015 at 11:42 A.M., CNA #2 was observed carrying a clothing protector, draped over her left arm and against her uniform to a dining room table while speaking to residents. She was then observed to return the clothing protector back into the clean linen cabinet in the dining room.</p> <p>On 2/18/2015 at 2:40 P.M. and 3:30 P.M., in Resident #17's bathroom, soiled towels were observed on the floor under the sink.</p> <p>On 2/19/2015 at 9:00 A.M., in Resident #12's bathroom, soiled towels were observed on the floor under the sink. At</p> |   | <p>the facility by the survey team. The facility will provide resident #12 with a small receptacle in her bathroom, in which she will be requested to place her soiled linens for staff to remove later. All residents residing in the facility have the potential to be affected by this finding. CORRECTIVE ACTION(S): For those residents who place soiled linens on the floor, the facility will provide a small receptacle, in which they will be requested to place their soiled linens for staff to remove later. This receptacle will be placed in their bathroom or in an area of their choice, providing it does not create a safety hazard. All staff will be re-educated regarding the policy for "Linen Handling," including that linen should not be held against the staff member's uniform during transport or delivery and that linen or laundry on the floor is to be placed in the soiled linen hamper. This in-service is to be completed by 03/23/15. MONITORING TO PREVENT RECURRENCE: Daily for four weeks, then weekly for 4 weeks, then monthly, Facility managers will inspect resident rooms and observe staff handling linen, in order to check for proper infection control practices related to handling linen. (Attachment H -- Linen Handling Review) As necessary, the managers will address any observed violations of policy by immediately</p> |                      |   |

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|  | <p>this same time, during an interview, Resident #12 indicated she would place soiled linens on the floor after she completed morning care and staff would pick up the linens later in the morning. At 10:05 A.M., in Resident #12's bathroom, the soiled towels were observed to still be on the floor.</p> <p>During an interview, on 2/23/2015 at 10:24 A.M., Housekeeper #3 indicated resident's personal clothing should be carried on a hanger.</p> <p>During an interview, on 2/23/2015 at 1:11 P.M., CNA #1 indicated soiled linen barrels were kept in soiled utility room. She indicated independent residents would place soiled linens on the floors in their rooms. She also indicated staff would periodically pick up soiled linens, or the residents would bring linens out to staff, to place in soiled utility room.</p> <p>On 2/23/2015 at 10:55 A.M., review of current facility policy labeled "Linen Handling," dated 6/9/2010, and provided by Administrator 2/23/15 at 10:30 A.M., indicated the following: "...E. If clean linen or laundry i.e. clothing should drop on the floor, it will be placed in the soiled linen hamper. F. Linen should not be held against the staff member's uniform during transport or delivery...."</p> |   | <p>re-educating staff. The results of the manager inspections will be submitted to the Infection Control Nurse, who will provide further training to staff as needed. The Infection Control Nurse will report monthly to the QA Committee regarding the findings from manager inspections and observations, as well as actions taken to correct and re-educate. The QA Committee will review the report and make any further stored and transported in accordance with policy and proper infection control practices.</p> |   |  |   |  |

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