

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00147204.</p> <p>Complaint IN00147204: Substantiated, no deficiencies related to the allegation are cited.</p> <p>Survey dates: April 21, 22, 23, 24 & 25, 2014</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Survey team: Cynthia Stramel, RN-TC Heather Tuttle, RN Yolanda Love, RN Lara Richards, RN</p> <p>Census bed type: SNF/NF: 72 SNF: 10 Total: 82</p> <p>Census payer type: Medicare: 16 Medicaid: 56 Other: 10 Total: 82</p>	F000000		

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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F000157 SS=D	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interviews, the facility failed to ensure the resident's</p>	F000157	F-Tag 157 Notify of Changes It is the policy of Miller's Merry	05/25/2014			

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	<p>Physician was promptly notified as well as the resident's responsible party related the treatment and deterioration of pressure ulcers for 2 of 3 residents reviewed for pressure ulcers of the 6 who met the criteria for pressure ulcers. (Residents #68 & #126)</p> <p>Findings include:</p> <p>1. The closed record for Resident #126 was reviewed on 4/23/14 at 2:33 p.m. The resident's diagnoses included, but were not limited to, nutritional deficiencies, hyperlipidemia, and thyroid disorder. The resident was admitted to the facility on 12/17/13.</p> <p>Further record review indicated the resident had many hospital admissions while at the facility. The resident was admitted to the hospital on 1/27/14 and returned to the facility on 2/4/14. She was admitted to the hospital on 2/6/14 and returned on 2/10/14. The resident was admitted to the hospital on 3/16/14 and returned on 3/23/14. The resident's final admission to the hospital was on 4/15/14, in which she was discharged from the facility at that time.</p> <p>The resident was admitted with a pressure ulcer to her coccyx on 12/17/13 in which it gradually declined in status</p>		<p>Manor, Hobart to promptly inform the resident; consult with resident's physician, notify resident's legal representative or an interested family members when there is a significant condition change in the resident's physical, mental, or psychosocial status and or/the need to alter treatment significantly. Resident # 126: Resident has been discharged from the facility. Resident # 68: The Physician and Family was notified of resident's status and/or the need to alter treatment significantly. <i>All residents are at risk to be affected by the deficient practice.</i> All licensed nursing staff will be in-serviced on facility policy for "Notification of Changes" (Attachment A) by 5/22/14. Nurses will be instructed to document in the EMR any significant condition change in a resident's physical, mental, or psychosocial status and or/the need to alter treatment significantly. The nurse managers review the EMR 24 hours condition report daily to ensure that significant changes in status are communicated to physician per policy. The DON or other designee will be responsible to complete the QA tool titled "24 Hour Condition Review" (Attachment B) daily x 1week, then bi-weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter to monitor for ongoing compliance. Any</p>				

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	<p>over the course of the hospital admissions.</p> <p>Review of the pressure ulcer wound report dated 3/26/14 (right after the last readmission from the hospital) indicated the resident had a pressure ulcer to her coccyx that was classified as a healing Stage IV. The wound measured 3.4 centimeters (cm) by 1 cm. by .5 cm. with 75% thin slough (necrotic tissue) and 10% granulation. There was 1 cm. of undermining present at 9-12 on clock face with light serous drainage. The box for Physician and family notification was blank.</p> <p>Further review of the pressure ulcer wound report dated 4/2/14 indicated a healing Stage IV pressure ulcer to the coccyx. The status of the ulcer indicated "No change." The ulcer measured 3.4 centimeters (cm) by 1 cm. by .5 cm. with 75% thin slough (necrotic tissue) and 10% granulation. There was 1 cm. of undermining present at 9-12 on clock face with light serous drainage. The box for Physician and family notification was blank.</p> <p>The last documented pressure ulcer wound report assessment was dated 4/9/14. The report indicated the resident had a healing Stage IV pressure ulcer to</p>		<p>identified trends will be corrected and logged on facility QA tracking log. The QA tracking logs are reviewed during the facility monthly QA meeting to ensure ongoing compliance. Date of Compliance: 5/25/2014</p>				

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	<p>the coccyx. The status of the ulcer indicated "No change." The ulcer measured 3.4 centimeters (cm) by 1 cm. by .5 cm. with 75% thin slough (necrotic tissue) and 10% granulation. There was 1 cm. of undermining present at 9-12 on clock face with light serous drainage. The box for Physician and family notification was blank.</p> <p>Review of Nursing Progress Notes dated 3/26-4/15/14 indicated there was no evidence of any documentation the Physician and/or family member was notified the pressure ulcer had not improved in two weeks time.</p> <p>Review of the current 8/3/2010 Pressure Ulcer Treatment policy provided by the Director of Nursing on 4/24/14 indicated, "Re-evaluate the pressure ulcer, the plan of care and the individual if the pressure ulcer does not show progress towards healing within two weeks. Notify the Physician of any signs of deterioration in the pressure ulcer."</p> <p>Interview with the Wound Nurse on 4/25/14 at 11:40 a.m., indicated she was aware she needed to notify the resident's family and/or Physician when there was a change, a decline or no improvement of the pressure ulcers.</p>						

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	<p>2. The record for Resident #68 was reviewed on 4/24/14 at 8:46 a.m. The resident was admitted to the facility on 10/15/07 and readmitted to the facility on 3/16/13. The resident's diagnoses included, but were not limited to, cardiovascular disease, anemia, legal blindness, diabetes, hemiplegia with hemiparesis.</p> <p>Review of Physician Orders dated 4/8/14 indicated wound nurse to follow left foot, bottom of second toe.</p> <p>Review of the wound assessment dated 4/9/14 completed by the Wound Nurse indicated the resident developed a Stage II pressure ulcer to the tip of the second toe on his left foot. The ulcer measured .3 centimeters (cm) by .4 cm by .2 cm. The wound bed showed 100% granulation tissue with some drainage noted. The notes indicated an order to cleanse with normal saline, apply Santyl (a debriding agent) and cover with gauze and change daily. The Physician and family notification section was not completed and left blank.</p> <p>Further review of the wound assessment dated 4/16/14 indicated the pressure ulcer was now a Stage III and measured .3 cm by .4 cm by less than .1 cm. The wound bed showed 50% yellow slough (necrotic</p>			

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	<p>tissue) and 50% of granulation tissue. The notes indicated to continue the same order. The Physician and family notification section was not completed and left blank.</p> <p>Review of Nursing Progress Notes dated 4/9/14-4/23/14 indicated there was no evidence of any documentation the resident's Physician was notified of the treatment of Santyl to the toe, nor was the Physician notified of the increase in the stage of the pressure ulcer from a Stage II to a Stage III. There was no evidence the resident's family was notified of the new treatment or the decline of the pressure ulcer as well.</p> <p>Review of the current 1/3/2003 Physician and Family Notification of Condition Change policy provided by the Director of Nursing on 4/24/14 indicated, "Notify the Physician of any change in condition that may or may not warrant a change in the treatment plan. Document the information reported to the Physician in the Nurses notes including the time and date of notification. Be thorough and explicit."</p> <p>Review of the current 8/3/2010 Pressure Ulcer Treatment policy provided by the Director of Nursing on 4/24/14 indicated, "Notify the Physician of any signs of</p>				

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F000241 SS=D	<p>deterioration in the pressure ulcer."</p> <p>Interview with LPN #2 on 4/24/14 at 10:50 a.m. indicated she saw the pressure sore on 4/8/14 during the resident's skin assessment after his shower. The LPN indicated she notified the Physician and he indicated for the wound nurse to follow. The LPN also indicated she notified the resident's family member of the pressure ulcer. The LPN further indicated she did not notify the resident's Physician and/or family member of the treatment of the pressure ulcer or the deterioration of the pressure ulcer.</p> <p>Interview with the Wound Nurse on 4/25/14 at 11:40 a.m. indicated she was aware she needed to notify the Physician and family member when there was a change in condition or treatment for the resident.</p> <p>3.1-5(a)(2)</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.</p> <p>Based on observation and interview, the</p>	F000241	F241 Dignity and Respect of Individuality: It is the policy of Miller's Merry Manor Hobart to	05/25/2014			

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	<p>facility failed to ensure a resident's dignity was maintained related to staff discussing medical concerns in the dining room where other resident's and visitors could hear for 1 of 1 resident reviewed for dignity. (Resident #141)</p> <p>Findings include:</p> <p>On 4/22/14 at 12:10 p.m., Resident #141 was in the East dining room with four family members and the Speech Therapist. There were three female residents seated at the table next to him eating lunch. A male family member was discussing the resident's bowel concerns with the Speech Therapist. They were speaking loudly and could be heard at the nurses station. The Speech Therapist indicated dietary guidelines and medication interventions related to constipation. She went to the nurses station and checked the resident's record, she confirmed the use of decussate for constipation with LPN #1, and then returned to the dining room. The Speech Therapist and family member continued to speak loudly about the resident's bowel patterns.</p> <p>Interview with LPN #1 at 12:20 p.m., indicated that 2 of the 3 female resident's seated at the next table were alert and oriented. She indicated she had also</p>		<p>promote care for the residents in an environment that maintains or enhances each resident's dignity and respect in full recognition of the his or her individuality.</p> <p>Resident: # 141: The speech therapist was educated immediately on resident's rights to privacy and dignity. <i>All residents in the facility have the potential to be affected by this deficient practice.</i> The facility will educate all staff regarding the importance of HIPPA and speaking to residents and their family members in a private area to discuss healthcare concerns on or before 5/22/14. The administrator, social service designee, and nurse managers will be responsible to participate in routine walking rounds of the facility on varying shifts and at different times to monitor that residents, family and staff are discussing healthcare concerns in a dignified manner such as in private areas. The corrective action will be monitored utilizing the QA tool "Quality Care Review" (Attachment C). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to</p>		

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F000282 SS=D	<p>overheard the conversation regarding bowel concerns with the Speech Therapist and the family member.</p> <p>Interview with the Director of Nursing on 4/24/14 at 8:40 a.m., indicated staff should speak with family members regarding residents health concerns in private, where they cannot be overheard by other residents or visitors.</p> <p>3.1-3(o)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure each resident's plan of care was followed related to Physician notification of pressure ulcers and for monitoring and assessing for pain for 1 of 3 residents reviewed for pressure ulcers and for 1 of 1 residents reviewed for pain. (Residents #34 and #68)</p> <p>Findings include:</p>	F000282	<p>ensure ongoing compliance. Date of Compliance: 5/25/2014</p> <p>F-Tag 282 Services by Qualified Persons/Per Care Plan: It is the policy of Miller's Merry Manor, Hobart that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care related to pain management, treatments, and assessments. Resident # 68: Physician and Family were notified of change/decline of wound. The assessment documentation was also</p>	05/25/2014			

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	<p>1. The record for Resident #68 was reviewed on 4/24/14 at 8:46 a.m. The resident was admitted to the facility on 10/15/07 and readmitted to facility on 3/16/13. The resident's diagnoses included, but were not limited to, cardiovascular disease, anemia, legal blindness, diabetes, hemiplegia with hemiparesis.</p> <p>Review of the 4/15/14 Significant Change Minimum Data Set (MDS) Assessment indicated the resident was at risk for developing pressure sores and had one Stage II pressure ulcer.</p> <p>Review of the care plan dated 4/15/14 indicated wound actual skin breakdown, location tip of left second toe. The Nursing approaches were for the Nurse to measure and assess weekly and notify family and Physician as needed.</p> <p>Review of Physician Orders dated 4/8/14 indicated wound nurse to follow to left foot bottom of second toe.</p> <p>Review of the wound assessment dated 4/9/14 completed by the Wound Nurse indicated the resident developed a Stage II pressure ulcer to the tip of the second toe on his left foot. The ulcer measured .3 centimeters (cm) by .4 cm by .2 cm. The wound bed shows 100% granulation</p>		<p>corrected for this resident Resident # 34: Resident was assessed by the nurse on 04/24/2014. Findings of this assessment were documented. The Physician and family were notified and orders were received and noted. Pain level will continue to be assessed per facility policy. Policy for pain does not require pre/post pain assessment for routine pain management. Nursing will monitor for s/s of break thru pain daily. Prior to administration of any PRN pain medication pre and post assessment will be completed using a 1-10 scale to evaluate effectiveness. <i>All residents are at risk to be affected by the deficient practice.</i> All licensed nursing staff in-service will be completed on or before 5/22/14 to review the process for ensuring physician and family are notified of change/decline in wounds, assessments, and physicians orders for pain management are delivered as ordered or indicated in residents individual HCP. The facility pain policy will be reviewed and charge nurses will be instructed to use the prn pain flow sheet to record pre and post pain assessment for prn pain medication use. A scale of 1-10 will be utilized to measure pain level. Residents who are receiving routine pain medications for pain management programs will continue to be assessed</p>		

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	<p>tissue with some drainage noted. The notes indicated an order to cleanse with normal saline, apply Santyl (a debriding agent) and cover with gauze and change daily. The Physician and family notification section was not completed and left blank.</p> <p>Further review of the wound assessment dated 4/16/14 indicated the pressure ulcer was now a Stage III and measured .3 cm. by .4 cm. by less than .1 cm. The wound bed shows 50% yellow slough (necrotic tissue) and 50% of granulation tissue. The notes indicated to continue the same order. The Physician and family notification section was not completed and left blank.</p> <p>Review of Nursing Progress Notes dated 4/9/14-4/23/14 indicated there was no evidence of any documentation the resident's Physician was notified of the treatment of Santyl to the toe, nor was the Physician notified of the increase in the stage of the pressure sore from a Stage II to a Stage III. There was no evidence the resident's family was notified of the new treatment or the decline of the pressure ulcer as well.</p> <p>Interview with the Wound Nurse on 4/25/14 at 11:40 a.m. indicated she was aware she needed to notify the Physician</p>		<p>weekly with weekly summary assessment, pre and post PRN pain medications, during MDS assessment, and with pertinent significant change in status. The DON or other designee will be responsible to complete the "MAR/TAR/Weekly Summary Review" (Attachment D) daily x1 week, then 3x weekly x 4 weeks, then weekly x4 weeks, and monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected upon discovery and documented on facility QA tracking log. QA tracking logs are reviewed monthly during the facility QA meeting. Date of Compliance: 5/25/2014</p>	

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F000309 SS=E	<p>and family member when there was a change in condition or treatment for the resident.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to assess and monitor bruises for 3 of 3 residents reviewed for skin conditions (non-pressure related) of the 4 residents who met the criteria for skin conditions (non-pressure related). The facility also failed to ensure a resident's arteriovenous (AV) fistula was accurately assessed for 1 of 1 residents reviewed for dialysis and that a resident's pain status was accurately assessed and monitored for 1 of 1 residents reviewed for pain. (Residents #20, #34, #41, and #145)</p> <p>Findings include:</p> <p>1. On 4/22/14 at 10:37 a.m. and 3:25 p.m., Resident #20 was observed to have a bluish discoloration to the top of her left hand extending to her thumb area. The resident was also observed to have a fading green bruise to the top of her right</p>	F000309	<p>F-Tag 309 Provide Care/Services for Highest Well Being: It is the policy of Miller's Merry Manor, Hobart to ensure that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident # 20: Assessment was completed and documented for this resident. Physician and Family were notified and orders received and noted; HCP updated. Resident # 41: Assessment was completed and documented for this resident. Physician and Family were notified and orders received and noted; HCP updated. Resident # 145: Assessment was completed and documented for this resident. Physician and Family were notified and orders received and noted; HCP updated. Resident # 34: Assessment was completed</p>	05/25/2014

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	<p>hand near the wrist area.</p> <p>On 4/23/14 at 9:21 a.m. and 10:37 a.m., the area of bluish discoloration to the top of the resident's left hand and thumb area remained as well as the fading green discoloration to the top of the resident's right wrist.</p> <p>The record for Resident #20 was reviewed on 4/23/14 at 9:26 a.m. A Physician's Order dated 11/27/13 and listed on the April 2014 Physician's Order Summary (POS), indicated the resident was to receive 81 milligrams (mg) of Aspirin daily.</p> <p>Review of the Nursing progress notes for the month of April 2014, indicated the last entry was dated 4/17/14. There was no documentation of any bruising to the resident's hands.</p> <p>Review of the Weekly Nursing Assessments dated 4/11 and 4/18/14, indicated no skin issues were noted.</p> <p>On 4/24/14 at 10:42 a.m., the Central Unit Manager was taken to the resident's room. The Unit Manager confirmed the presence of the fading bruises to the resident's left hand extending to the thumb and on the right wrist area.</p> <p>Interview with the Unit Manager at the</p>		<p>and documented for this resident. Physician and Family were notified and orders received and noted. All residents are at risk to be affected by the deficient practice. On 4/24/14, all resident's skin was assessed, "skin sweep." No other residents were affected. No other resident was noted to have a fistula. The facility pain policy will be reviewed and charge nurses will be instructed to use the prn pain flow sheet to record pre and post pain assessment for prn pain medication use. A scale of 1-10 will be utilized to measure pain level. Residents who are receiving routine pain medications for pain management programs will continue to be assessed weekly with weekly summary assessment, pre and post PRN pain medications, during MDS assessment, and with pertinent significant change in status. All licensed nursing staff will be in-serviced by 5/22/14 regarding assessing, documenting and monitoring of bruises according to the facilities policy. All licensed nursing staff will also be in-serviced by 5/22/2014 regarding assessing and documentation of dialysis resident's according to the facilities policy. The corrective action will be monitored utilizing the QA tool "Quality Care Review" (Attachment C). Tool will be completed daily for 1 week, then</p>		

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	<p>time, indicated if a bruise or skin tear was noted in between the resident's weekly skin assessment time frame, an occurrence form was initiated or at least documentation was put on the Treatment Administration Record (TAR) to monitor the bruising. Review of the April 2014 TAR after the interview, indicated no occurrence form had been completed nor had documentation been put on the TAR.</p> <p>Review of the Nursing progress notes on 4/25/14 at 10:00 a.m., indicated an entry had been completed on 4/24/14 at 4:30 p.m. which indicated the Physician had been notified of old discolorations to the resident's bilateral wrists and hands, no new orders given at this time. Family also made aware and the discoloration was to be monitored for 7 days.</p> <p>2. On 4/22/14 at 11:02 a.m. and 3:25 p.m., Resident #41 was observed with reddish purple bruising to the top of her left and right hands.</p> <p>On 4/23/14 at 9:20 a.m., the resident was observed with reddish purple discolorations to her left and right hands as well as a reddish purple bruise to her right upper arm. At 11:07 a.m., an area of reddish purple discoloration was observed on the resident's left wrist area near her watch band.</p>		<p>3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance. Date of Compliance: 5/25/2014</p>				

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	<p>On 4/24/14 at 6:45 a.m., and 2:15 p.m., the resident was observed with multiple areas of reddish purple discoloration to her left and right hands as well as her left and right arms.</p> <p>The record for Resident #41 was reviewed on 4/23/14 at 2:43 p.m. The resident's diagnosis included, but was not limited to, anemia.</p> <p>A Physician's Order dated 4/18/14, indicated the resident was to receive Coumadin (a blood thinner) 4 milligrams (mg) daily.</p> <p>Review of the 4/18/14 Readmission Assessment indicated the resident had multiple bruising to the total surface area of bilateral lower arms. There was no specific documentation of where the bruises were actually located on the bilateral lower arms.</p> <p>There was no documentation of the bruising on the 72 hour follow up readmission assessments dated 4/19, 4/20, and 4/21/14.</p> <p>Review of the Treatment Administration Record (TAR) on 4/24/14 at 10:45 a.m., indicated there was an entry to monitor discoloration to the bilateral arms for 7</p>			

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F000441 SS=D	<p>days on the 7-3 shift. The TAR was signed out 4/21-4/25/14.</p> <p>Interview with the Unit Manager on 4/24/14 at 10:40 a.m., indicated when a resident was admitted with multiple areas of bruising, it should be documented in the Admission Assessment and on the TAR. She indicated that she did not know if the areas would be measured but at least the location should have been documented on the full body diagram on the assessment.</p> <p>Review of the Initial skin sheet for redness of the right upper arm initiated on 4/24/14, indicated "discolorations noted to right upper arm, just above elbow. Discolorations to right upper arm just above anticubital. Measures approximately 5.5 centimeters (cm) x 2 cm and 3 cm x 1.5 cm."</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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>						

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	<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> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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 and interview the facility failed to maintain infection control policies and standards related to properly storing resident's urine collection container, toothbrush, and wash basins for 10 rooms in a sample of 35 rooms for 1 of 3 units in the facility. (West Unit Room #5, #11, #12, #16, #17, #19, #20, #23, #25, and #29.)</p>	F000441	F-Tag 441:Infection Control It is the policy of Miller's Merry Manor, Hobart 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. Room #5, #11, #12, #16, #17, #19, #20, #23, #25 and #29: Tooth brushes will be stored	05/25/2014			

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	<p>Findings include:</p> <p>On 4/22/14 at 9:12 a.m., the following was observed on the West Unit:</p> <p>a. A wash basin was observed uncovered and stored on top of the toilet seat in the bathroom in Room 5. Two residents resided in this room.</p> <p>b. A toothbrush was observed uncovered and stored on top of the sink. There were two wash basins observed uncovered and stored on top of the toilet seat in the bathroom in Room 11. Two residents resided in this room.</p> <p>c. Two wash basins were observed uncovered and stored on top of the sink in the bathroom in Room 12. Two residents resided in this room.</p> <p>d. Two wash basins were observed uncovered and stored on top of the sink in the bathroom in Room 16. Two residents resided in this room.</p> <p>e. Two wash basins were observed uncovered and stored on top of the sink in the bathroom in Room 17. Two residents resided in this room.</p> <p>f. A toothbrush was observed uncovered and stored on top of the sink in the</p>		<p>in a zip lock bag in residents bedside table; urine collection containers and wash basins will be stored in individual plastic bags and placed in the bathrooms. All residents are at risk to be affected by the deficient practice. All nursing staff in-service will be held on or before 5/22/14 to review the facility policy/procedure on basic infection control practices for proper storage of tooth brushes, urine collection containers and wash basins. The Nurse Managers will be responsible to make random walking rounds, Room Round Checklist (Attachment E) on all shifts to monitor for continued compliance with proper storage of tooth brushes, urine collection containers and wash basins. Any issues identified during observation will be immediately corrected and documented on facility QA tracking tool. The facility reviews all tracking logs during the monthly QA meeting to ensure ongoing compliance. Date of Compliance: 5/25/2014</p>		

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	<p>bathroom in Room 19. Two residents resided in this room.</p> <p>g. Two wash basins were observed uncovered and stored on top of the toilet in the bathroom in Room 20. Two residents resided in this room.</p> <p>h. A urine collection container was observed uncovered and stored on the back of the toilet in the bathroom in Room 23. Two residents resided in this room.</p> <p>i. Two wash basins were observed uncovered and stored on top of the toilet in the bathroom in Room 25. Two residents resided in this room.</p> <p>j. A urine collection container was stored uncovered on the bathroom floor. Two wash basins were observed uncovered and stored on the floor in the bathroom in Room 29. Two residents resided in this room.</p> <p>Interview with the Housekeeping Supervisor on 4/25/14 at 10:40 a.m., indicated resident ' s urine collection containers, wash basins, and toothbrushes should not be stored uncovered.</p> <p>3.1-18(j)</p>						

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F000463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation and interview, the facility failed to ensure residents were provided a functioning call system device at the bedside for 1 room in a sample of 35 rooms. (Room #142-1)</p> <p>Findings include:</p> <p>On 4/22/2014 at 8:56 a.m., an observation was made in Room 142-1. The call light system failed to function properly. When the call button was pressed the light failed to stay illuminated, the call light also failed to continue to alert at the Nursing station.</p> <p>Interview with the Unit Manager on 4/25/14 at 2:00 p.m., indicated she was not aware the call light system was not working properly in Room 142-1. Maintenance was immediately called to replace the call light at the time.</p>	F000463	<p>F-Tag 463: Resident Call System- Rooms/Toliet/Bath It is the policy of Miller's Merry Manor, Hobart that each nurse's station will be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Room 142-1 All residents in the facility have the potential to be affected by these findings. A call light audit was completed to address any other areas that have the potential to affect other residents on 4/26/14. Call light system will be monitored using the Room Round Checklist (Attachment E) by Department Managers daily x1 week, then 3x weekly x 4 weeks, then weekly x4 weeks, and monthly thereafter to monitor for ongoing compliance. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing</p>	05/25/2014			

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F000465 SS=E	<p>3.1-19(u)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE 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 ensure the resident's environment was clean and in good repair related to stained ceiling tiles, marred walls and doors, loose sinks, missing and dusty ceiling vents, and urine odors for 2 of 3 units in the facility. (West and Central Units)</p> <p>1. During the Environmental Tour on 4/25/14 at 10:10 a.m., with the Environmental Supervisor, Housekeeping Supervisor, and Maintenance the following was observed:</p> <p>West Unit:</p> <p>a. There was a brownish/mildew substance on the wall near the toilet in the bathroom in Room 5. One resident resided in this room.</p> <p>b. The ceiling tiles in the bathroom in</p>	F000465	<p>compliance. Date of Compliance: 5/25/2014</p> <p>F-Tag 465: Safe/Functional/Sanitary/Comfortable Environment It is the policy of Miller's Merry Manor, Hobart to provide a safe and sanitary environment. All issues identified during the environmental tour were corrected on or before 5/25/14. All residents in the facility have the potential to be affected by these findings. An environmental walk through audit was completed to address any other areas that have the potential to affect other residents on or before 5/25/14. To ensure that this does not re-occur housekeeping supervisor and or designee will conduct daily rounds using the "Room Preparation Checklist" (Attachment F) three rooms, per unit daily for four weeks then two rooms, per unit weekly thereafter. Housekeeping and maintenance staff will be re-inserviced on cleaning procedures and identifying safety</p>	05/25/2014	

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	<p>Room 10 were stained. The paint near the window was scratched and peeling. One resident resided in this room.</p> <p>c. The ceiling vent in the bathroom in Room 11 was dusty. Two residents resided in this room.</p> <p>d. The caulking around the bathroom sink in Room 12 was cracked. Two residents resided in this room.</p> <p>e. The bathroom walls in Room 16 were marred. The chair rail behind bed 1 was broken. Two residents resided in this room.</p> <p>f. The bathroom walls in Room 17 were in need of painting. The caulking around the bathroom sink was cracked. The chair rail over bed 2 needed painting. Two residents resided in this room.</p> <p>g. The bathroom in Room 20 had an odor of urine. The caulking around the bathroom sink was chipped. There was no ceiling vent cover in the bathroom. Two residents resided in this room.</p> <p>h. The wall behind bed 1 in Room 25 was scratched and peeling. Two residents resided in this room.</p> <p>i. There was no privacy curtain in Room</p>		<p>concerns in resident areas by 5/25/2014. Monitoring of the effectiveness of the system will be done weekly for four weeks and then monthly thereafter by the Administrator or designee using the General Observations Audit tool as part of the QA program. Date of Compliance: 5/25/2014</p>				

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	<p>29. The bathroom sink was loosely affixed to the wall. One resident resided in this room.</p> <p>Central Unit:</p> <p>a. The door frame to the bathroom in Room 140 was scratched and marred. The walls in the bathroom were scratched and marred. Two residents resided in this room.</p> <p>b. The plastic trim around the entry door frame was chipped in Room 142. The paint on the door frame to the bathroom was chipped and marred. There were stained ceiling tile in the bathroom. There was a white material peeling from the toilet seat. There was a residue from the non-skid strips on the floor near bed 2. Two residents resided in this room.</p> <p>c. The door frame to the bathroom in Room 147 was chipped and marred. The wall behind the toilet was discolored. The wood was peeling from the drawer around the bathroom sink. Two residents resided in this room.</p> <p>d. There was an odor of urine in the bathroom in Room 148. The bathroom walls were marred and peeling around the baseboards. The ceiling tiles in the bathroom were stained. Two residents</p>			

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	<p>resided in this room.</p> <p>e. The plastic trim at the base of the entry door to Room 153 was cracked in sections. The ceiling tile in the bathroom around the sprinkler was discolored with an orange substance. Two residents resided in this room.</p> <p>2. On 4/21/14 at 8:20 a.m., there was an odor of urine on the West Unit.</p> <p>On 4/22/14 at 8:29 a.m., there was an odor of urine on the West Unit.</p> <p>On 4/24/14 at 9:00 a.m., there was an odor of urine in the Central Unit.</p> <p>Interview with Environmental Supervisor at this time indicated the above mentioned items were in need of cleaning and or repair.</p> <p>3.1-19(f)</p>						

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview and record review, the facility failed to identify the non-compliance related to documenting and monitoring non-pressure skin problems such as bruises, through the facility's quality assurance protocol. (Residents #20, #41 and #145)</p> <p>Findings include: Interview with the Inservice Director,</p>	F000520	<p>F-Tag 520: QAA Committee-Members/Meet Quarterly/Plans It is the policy of Miller's Merry Manor, Hobart to maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. Resident # 20: Assessment was completed and documented for this resident. Physician and Family were notified and orders received and</p>	05/25/2014			

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	<p>who was identified as the Quality Assurance Committee (QAC) Leader, on 4/25/14 at 2:30 p.m., indicated the QAC consisted of herself, the Administrator, the Director of Nursing, the Medical Director, department heads and pharmacy representative. She indicated the committee met monthly. The Inservice Director indicated she had inserviced nursing staff in January 2014, related to the monitoring and documenting of non-pressure skin issues, such as bruises. She indicated there was not a system in place to ensure such monitoring and documenting was being completed. She further indicated that lack of monitoring and documenting bruises had not been identified or discussed in QAC meetings. She indicated that records would be audited for such documentation in the future.</p> <p>1. On 4/22/14 at 10:37 a.m. and 3:25 p.m., Resident #20 was observed to have a bluish discoloration to the top of her left hand extending to her thumb area. The resident was also observed to have a fading green bruise to the top of her right hand near the wrist area.</p> <p>On 4/23/14 at 9:21 a.m. and 10:37 a.m., the area of bluish discoloration to the top of the resident's left hand and thumb area remained as well as the fading green</p>		<p>noted; HCP updated. Resident # 41: Assessment was completed and documented for this resident. Physician and Family were notified and orders received and noted; HCP updated. Resident # 145: Assessment was completed and documented for this resident. Physician and Family were notified and orders received and noted; HCP updated. All residents are at risk to be affected by the deficient practice. All licensed nursing staff will be in-serviced by 5/22/14 regarding assessing, documenting and monitoring of bruises according to the facilities policy. All staff will be in-serviced by 5/22/14 on identifying any concerns in the facility and reporting those to the QAA committee. The Nurse Managers will be responsible to make random walking rounds on all shifts to monitor for any concerns with residents that have not been addressed and needs to be reported to the QAA committee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance. Date of Compliance: 5/25/2014</p>				

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	<p>discoloration to the top of the resident's right wrist.</p> <p>The record for Resident #20 was reviewed on 4/23/14 at 9:26 a.m. A Physician's Order dated 11/27/13 and listed on the April 2014 Physician's Order Summary (POS), indicated the resident was to receive 81 milligrams (mg) of Aspirin daily.</p> <p>Review of the Nursing progress notes for the month of April 2014, indicated the last entry was dated 4/17/14. There was no documentation of any bruising to the resident's hands.</p> <p>Review of the Weekly Nursing Assessments dated 4/11 and 4/18/14, indicated no skin issues were noted.</p> <p>On 4/24/14 at 10:42 a.m., the Central Unit Manager was taken to the resident's room. The Unit Manager confirmed the presence of the fading bruises to the resident's left hand extending to the thumb and on the right wrist area. Interview with the Unit Manager at the time, indicated if a bruise or skin tear was noted in between the resident's weekly skin assessment time frame, an occurrence form was initiated or at least documentation was put on the Treatment Administration Record (TAR) to monitor</p>				

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	<p>the bruising. Review of the April 2014 TAR after the interview, indicated no occurrence form had been completed nor had documentation been put on the TAR.</p> <p>Review of the Nursing progress notes on 4/25/14 at 10:00 a.m., indicated an entry had been completed on 4/24/14 at 4:30 p.m. which indicated the Physician had been notified of old discolorations to the resident's bilateral wrists and hands, no new orders given at this time. Family also made aware and the discoloration was to be monitored for 7 days.</p> <p>2. On 4/22/14 at 11:02 a.m. and 3:25 p.m., Resident #41 was observed with reddish purple bruising to the top of her left and right hands.</p> <p>On 4/23/14 at 9:20 a.m., the resident was observed with reddish purple discolorations to her left and right hands as well as a reddish purple bruise to her right upper arm. At 11:07 a.m., an area of reddish purple discoloration was observed on the resident's left wrist area near her watch band.</p> <p>On 4/24/14 at 6:45 a.m., and 2:15 p.m., the resident was observed with multiple areas of reddish purple discoloration to her left and right hands as well as her left and right arms.</p>						

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	<p>The record for Resident #41 was reviewed on 4/23/14 at 2:43 p.m. The resident's diagnosis included, but was not limited to, anemia.</p> <p>A Physician's Order dated 4/18/14, indicated the resident was to receive Coumadin (a blood thinner) 4 milligrams (mg) daily.</p> <p>Review of the 4/18/14 Readmission Assessment indicated the resident had multiple bruising to the total surface area of bilateral lower arms. There was no specific documentation of where the bruises were actually located on the bilateral lower arms.</p> <p>There was no documentation of the bruising on the 72 hour follow up readmission assessments dated 4/19, 4/20, and 4/21/14.</p> <p>Review of the Treatment Administration Record (TAR) on 4/24/14 at 10:45 a.m., indicated there was an entry to monitor discoloration to the bilateral arms for 7 days on the 7-3 shift. The TAR was signed out 4/21-4/25/14.</p> <p>Interview with the Unit Manager on 4/24/14 at 10:40 a.m., indicated when a resident was admitted with multiple areas</p>			

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	<p>of bruising, it should be documented in the Admission Assessment and on the TAR. She indicated that she did not know if the areas would be measured but at least the location should have been documented on the full body diagram on the assessment.</p> <p>Review of the Initial skin sheet for redness of the right upper arm initiated on 4/24/14, indicated "discolorations noted to right upper arm, just above elbow. Discolorations to right upper arm just above anticubital. Measures approximately 5.5 centimeters (cm) x 2 cm and 3 cm x 1.5 cm."</p> <p>3. The record for Resident #145 was reviewed on 4/23/14 at 8:30 a.m. The resident was admitted to the facility on 4/16/14. Diagnoses included, but were not limited to, left humerus (arm) fracture and dementia. The Minimum Data Set Assessment had not yet been completed.</p> <p>The resident was observed on 4/24/14 at 3:30 p.m. with the Unit Manager in her room. The resident had an immobilizer on her left arm. There was a bruise observed on her left upper arm, light blue and yellowish in color, approximately 3 centimeters (cm) wide.</p> <p>A Nursing Admission Assessment</p>						

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	<p>completed on 4/16/14 indicated there was a 6 cm x 5 cm bruise on the resident's left shoulder and a 6 cm x 3 cm bruise that was blue with yellowing edges to her left upper arm. There was a notation written in red on the computer assessment page that indicated, "All areas must be monitored at least daily til healed except bruises only monitor for 7 days unless problems noted".</p> <p>The following Nursing Assessments were reviewed: 4/17/14 at 2:46 p.m., skin was assessed, no issues documented. 4/18/14 at 8:28 a.m., skin was assessed, no issues documented. 4/19/14 at 10:23 p.m., skin was assessed, no issues documented. 4/20/14 at 5:32 p.m., skin was assessed, no issues documented. 4/21/14 8:02 p.m., skin was assessed, no issues documented. 4/22/14- No assessment 4/23/14 8:11 p.m., skin assessed, no issues documented.</p> <p>Interview with LPN #1 on 4/24/14 at 10:15 a.m., she indicated bruises should be monitored for seven days and documented in the Medication Administration Record (MAR) or the Nursing Notes. She indicated there were no assessments for the bruises</p>						

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	<p>documented in the MAR or the Nursing Notes.</p> <p>The policy titled Wound and Non-Wound Assessment and Documentation, dated 9/11/12 indicated, all non-wound skin alterations, which included bruises, will be managed by licensed nursing staff. The policy indicated, "Initial assessment and documentation will be completed on the Nursing-New skin alteration assessment or if on a new admit on the Nursing-Admission assessment". The policy further indicated, "Bruises will be monitored at least daily for 7 days for complications such as pain that may indicate need for further assessment".</p> <p>3.1-52(b)(2)</p>				