

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 06/18/2014
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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 Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 4/25/14.</p> <p>Survey dates: June 17 & 18, 2014</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Survey team: Cynthia Stramel, RN-TC Lara Richards, RN (6/17/14)</p> <p>Census bed type: SNF: 13 SNF/NF: 69 Total: 82</p> <p>Census payor type: Medicare: 14 Medicaid: 60 Other: 8 Total: 82</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 19, 2014, by Janelyn Kulik, RN.</p>	F000000		
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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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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure resident's care plans were followed related to not providing ADL (activities of daily living) care to a dependant resident and not using Geri-sleeves to protect the resident's arms for 1 of 4 residents reviewed for care plans. (Resident #76)</p> <p>Findings include:</p> <p>On 6/18/14 at 8:15 a.m., Resident #76 was observed in the main dining room. His eyes were closed and his chin was resting on his chest, he did not respond to his name. His plate was empty, and he had food, crumbs and mucus on his face and clothing protector. He was wearing a short sleeved shirt and he had multiple reddish/ purplish areas on both arms. He was not wearing Geri-sleeves. He had an intact dressing on his left hand. His oxygen was on, the left nasal cannula</p>	F000282	<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 # 76: Resident was re-dressed and geri-sleeves were applied; O2 cannula was applied correctly. The care plan was updated for non-compliance. <i>All residents are at risk to be affected by the deficient practice.</i> The Director of Nursing and Nurse Managers completed an audit of each residents plan of care by 6/27/14 to ensure resident specific interventions are in place and communicated via CNA assignment sheets to ensure ongoing compliance as indicated by individualized plan of care. All licensed & non-licensed nursing staff was in-serviced on 06/20/14 to review the facility policy on care plans and following residents care cards to ensure that care is</p>	06/27/2014			

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	<p>prong was in his right nostril, and the right prong was next to his nose.</p> <p>On 6/18/14 at 9:00 a.m., the resident was observed in his bed. The nasal cannula was still in the incorrect position, with the right prong next to his nose. He did not have Geri-sleeves on. His face was clean, but his shirt had a large wet spot on the front chest area. Family was seen entering the room at that time. The Administrator was notified of the concern at 9:06 a.m., and she indicated she would look at the resident.</p> <p>The resident's record was reviewed on 6/17/14 at 12:15 p.m. The resident was admitted to the facility on 1/4/13. Resident diagnoses included, but was not limited to, dementia and congestive heart failure (CHF).</p> <p>A Change in Therapy Minimum Data Set Assessment dated 5/26/14 indicated the resident's BIMS (brief interview for mental status) score was 03, which indicated he was cognitively impaired. His functional status indicated he was dependant on staff for dressing, personal hygiene, and bed mobility.</p> <p>A care plan dated 2/27/13 indicated the resident needed assistance with ADL's due to weakness. Goal was to have needs</p>		<p>done as indicated in residents individual HCP. The DON or other designee will be responsible to make random walking rounds, Room Round Checklist (Attachment A) on all shifts to monitor for continued compliance with according to residents HCP and care 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: June 27, 2014</p>				

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	<p>met and anticipated as evident by a clean, well groomed appearance.</p> <p>Another care plan dated 12/14/13 indicated the resident was at risk for chronic bruising and skin tears. The care plan was updated on 6/9/14 to include the approach of wearing Geri-sleeves to both arms.</p> <p>Further interview with the Administrator on 6/18/14 at 9:25 a.m., indicated when she entered the room a family member was present and had removed all of his clothing and oxygen, and was changing his clothes for lunch.</p> <p>This deficiency was cited on April 25, 2014. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p>				