

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/07/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 0548 S 100 W HARTFORD CITY, IN 47348
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 1, 2, 3, 4, and 7, 2014</p> <p>Facility number: 000289 Provider number: 155576 AIM number: 100289460</p> <p>Survey Team: Jason Mench, RN, TC Karen Koeberlein, RN Kim Davis, RN Angela Selleck, RN</p> <p>Census bed type: SNF: 3 SNF/NF: 46 Total: 49</p> <p>Census payor type: Medicare: 5 Medicaid: 40 Other: 4 Total: 49</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000		
F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>			

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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	<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 record review and interview, the facility failed to develop a comprehensive care plan for a mental illness diagnosis for 1 of 1 residents reviewed for level II recommendations. (Resident #7)</p> <p>Findings include:</p> <p>The clinical record of Resident #7 was reviewed on 4/3/14 at 1:35 p.m. The record indicated the resident's diagnoses included, but were not limited to, borderline personality disorder (mental illness) and depression.</p> <p>Review of the care plan indicated there was corresponding care plan addressing this mental illness.</p> <p>During an interview with the Nurse Consultant on 4/4/14 at 2:30 p.m., she indicated she could not find a care plan addressing Resident #7's diagnosis of borderline personality disorder and she would</p>	F000279	<p>F279 Develop Comprehensive Care Plans: It is the policy of Millers Merry Manor, Hartford City to use the results of assessments to develop, review, and revise the resident's comprehensive plan of care periodically.</p> <p>Resident #7 had no adverse effects as a result of this deficient practice. The nursing staff had identified mental illness on Resident #7's care plan, although it was listed under the cognition care plan and when Resident #7's cognition improved the care plan was resolved. Resident does not take medication for this diagnosis (borderline personality disorder).</p> <p>DON, SSD, and MDS coordinator have reviewed the care plan development and review policy as</p>	05/07/2014

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	<p>look into why there was not a care plan.</p> <p>During an interview with Minimum Data Set Assessment (MDS) Coordinator on 4/4/14 at 2:45 p.m., she indicated the diagnosis of borderline personality disorder was coded in Resident #7's MDS, but she could not find a care plan addressing Resident #7's diagnosis of borderline personality disorder.</p> <p>A facility policy "Care Plan Development & Review:" dated 2/11/10, provided by the Nurse consultant on 4/4/14 at 1:41 p.m. indicated:</p> <p>"1. PURPOSE: A. To assure that a comprehensive care plane 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 process..."</p> <p>"...F. Overall review of the care plan is completed in conjunction with the MDS quarterly, annual and significant change assessments..."</p> <p>3.1-35(a)</p>		<p>well as Resident #7's CAA summaries for each CAA that was triggered on most recent assessment dated 2-25-14. Upon review of most recent CAA summary, mood state and behavioral symptoms were not triggered; therefore care planning did not occur. Resident did trigger on the psychotropic med use due to depression and care plan is in place.</p> <p>All residents have the potential to be affected by this deficient practice. All residents who have triggered a Level II assessment have been reviewed by the social service department to ensure appropriate care plans are in place. No other issues were identified.</p> <p>Policies and Procedures have been reviewed regarding care plan development and review. See attachment A.</p> <p>To ensure that this deficient practice does not re-occur SSD or her designee will monitor all documentation related to level II assessments for accurateness weekly x1 month, bi-weekly x 1 month, then monthly x 4 months and until determined resolved by the QA committee. See attachment B. SSD or designee will ensure all qualifying diagnosis are listed on the care plan. SSD to make a copy of all Level II assessments for MDS coordinator to review as a double check. Any issues noted will be</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update the plan of care related to medication use for depression and insomnia for 1 of 5 residents reviewed for unnecessary medications. (Resident #17)</p> <p>Findings include:</p> <p>The clinical record for Resident #17 was reviewed on 4/3/14 at 9:15 a.m. Current diagnoses included, but were not limited to, protein-calorie malnutrition, congestive heart</p>	F000280	<p>logged on the QA summary log and reviewed and followed through the facility monthly QA meeting.</p> <p>Date of compliance 5-7-14.</p> <p>F280 Right to participate in planning care and treatment or changes in care and treatment: It is the policy of Miller's Merry Manor, Hartford City to revise the plan of care as needed as changes in the resident's condition dictate. Changes include but are not limited to changes in Physician orders, diet changes, therapy changes, behavior changes, ADL changes, skin changes, etc.</p>				

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	<p>failure, chronic obstructive pulmonary disease, dementia with behavioral disturbances, anxiety state, rheumatoid arthritis, essential hypertension, depressive disorder, debility and insomnia.</p> <p>The resident was currently receiving the following medications, on a daily basis Celexa (Antidepressant) originally ordered on 6/5/10 and Ambien (Hypnotic) originally ordered on 3/29/11.</p> <p>A review of Resident #17's Minimum Data Set (MDS) indicated the resident had significant changes in status assessment on 9/24/13 and 2/10/14.</p> <p>A review of Resident #17's care plans indicated the following:</p> <p>"Potential for side effects of psychotropic med use. Date initiated: 9/29/2010..." The last revisions to the care plan interventions were on 9/29/10.</p> <p>Interventions included: "Administer meds as ordered. Date Initiated: 9/29/2010; Evaluate effectiveness and side effects of medications daily. Date Initiated: 9/29/2010; Make attempts to reduce the dosage [sic] as appropriate. Date Initiated: 9/29/2010; Notify MD (Doctor of Medicine) or psych physician as needed. Date Initiated: 9/29/2010; Resident is at risk to experience mood problems related to dx (diagnosis) of agitation, anxiety and depression. Date Initiated: 9/29/10 Revision on: 3/30/2011..." The last revision to the care plan interventions were on 7/13/11.</p> <p>Interventions included: "Administer valproic acid blood level per physician orders. Date</p>		<p>Resident #17 had no adverse effects as a result of this deficient practice. The interdisciplinary team had reviewed resident #17's entire care plan per the review schedule. Another review of residents care plans was completed and appropriate revisions were made.</p> <p>All residents have the potential to be affected by this deficient practice. All other residents with psychotropic medication use will have review/revisions to their care plan as needed. All care plans are reviewed quarterly and with significant changes. Care Plans are also updated daily with any order changes.</p> <p>Policies and Procedures have been reviewed regarding care plan development and review. See attachment A.</p> <p>A mandatory in-service will be conducted on April 22, 2014 for all nursing staff. Care Plan development and review policy and procedures will be addressed so that all nursing staff is aware that care plans should be revised as needed as changes in the resident's condition dictate. We will be discussing care plans related to psychotropic medication use.</p> <p>To ensure that this deficient practice does not re-occur MDS coordinator or her designee will complete the</p>	

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	<p>Initiated: 3/30/2011 Revision on: 4/7/2011; Administer anti-depressant per MD orders and monitor for side effects each shift. Date Initiated: 9/29/2010; "Allow resident to verbalize fears or concerns. Date Initiated: 9/29/2010; "Listen attentively and follow-up on issues PRN (as needed). Date Initiated: 9/29/2010; "Per MD clinically contraindicated to reduce Celexa. Date Initiated: 7/13/2011; "Provide support and encouragement PRN. Date Initiated: 9/29/2010."</p> <p>"Sleeplessness/Insomnia related to: cognitive impairment, lifestyle choices. Date Initiated: 10/6/2010 Revision on: 3/30/2011..." The last revision to the care plan interventions were on 3/30/11.</p> <p>Interventions included: "Administer medication as ordered and document effectiveness. Date Initiated: 10/6/2010 Revision on: 1/21/2013; Elicit family input for best approaches to resident. Date Initiated: 10/6/2010 Revision on: 3/30/2011; Encourage adequate exercise throughout the day and discourage napping. Date Initiated: 10/6/2010 Revision on: 3/30/2011; Monitor for side effects of hypnotic medication and document every shift. Date Initiated: 1/21/2013; Requires rest periods throughout the day. Date Initiated: 10/6/2010 Revision on: 3/30/2011; Toilet prior to going to bed; follow toileting routine during night to maintain continence. Date Initiated: 10/6/2010 Revision on: 3/30/2011."</p> <p>A review of a care plan meeting note, dated 3/20/14, provided by the MDS Nurse on 4/4/14 at 11:30 a.m., indicated: "...9. Comments: "Resident recently admitted to Hospice services. She is physically stable,</p>		<p>QA tool Care Plan Review on 1/3rd of the resident population monthly x 3 months and then quarterly thereafter. See attachment C. Any issues will be corrected immediately and then concerns will be logged on the QA summary log and reviewed and followed through the facility monthly QA meeting.</p> <p>Date of compliance 5-7-14.</p>				

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F000282 SS=D	<p>but has had cognitive decline and weight loss..."</p> <p>During an interview with the Director of Nursing (DoN) and Social Service Director on 4/7/14 at 9:34 a.m., the DoN indicated Resident #17 was admitted to hospice 12/4/12 through 9/24/13 (for nine months) due to debility and readmitted to hospice on 2/10/14 due to protein-calorie malnutrition. The DoN indicated care plans are reviewed quarterly but had not seen a need to update or revise Resident #17's care plans related to medication use for depression and insomnia.</p> <p>A review of the policy titled "Care Plan Development & Review", dated 2/11/2010, provided by the Nurse Consultant on 4/4/14 at 1:41 p.m. indicated the following:</p> <p>"1. PURPOSE:</p> <p>A. 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 comprehensive assessment process...</p> <p>...3. CARE PLAN REVISION:</p> <p>A. Care plans will be revised daily and PRN (as needed) as changes in the resident's condition dictate. Changes include but are not limited to changes in Physician orders, diet changes, therapy changes, behavior changes, ADL's(activities of daily living), skin changes etc..."</p> <p>3.1-35(d)(2)(B) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER</p>						

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	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food preferences identified in a residents plan of care were honored, and a physician ordered dressing change was completed as ordered, for 1 of 11 residents residing in the facility who were reviewed for care plans and physician orders. (Resident #72)</p> <p>Findings include:</p> <p>The clinical record for Resident #72 was reviewed on 4/3/14 at 12:29 p.m. Diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus, malnutrition, and bilateral amputations of the lower limbs.</p> <p>During review of the admission care plan on 4/3/14 at 12:30 p.m., Resident #72 had a food preference which included fruit with all meals. Resident #72's most recent BIMS (Brief Interview for Mental Status) dated 3/24/14, indicated Resident #72 had no cognitive impairment. Resident #72's most current weight, dated 3/31/14, was 128 lbs.</p> <p>During an observation on 4/3/14 at 1:00 p.m., Resident #72's lunch meal did not include fruit along with the meal, as was preferenced on admission by Resident #72. Additional observations made on 4/4/14 at 1:00 p.m., and 4/7/14 at 1:25 p.m., indicated Resident #72's meals did not include fruit with the meal as was stated in the care plan.</p>	F000282	<p>F282 Services by Qualified Persons in accordance with each resident's written plan of care: It is the policy of Miller's Merry Manor, Hartford City to honor the residents preferences identified in their plan of care as well as complete dressing changes as ordered.</p> <p>Resident #72 had no adverse effects as a result of this deficient practice. The dressing change to residents g-tube site has since been discontinued as dressing was only a palliative treatment. The fruit at each meal has also been discontinued due to resident's preference.</p> <p>All residents have the potential to be affected by this deficient practice. All residents care plans regarding preferences and those with dressing changes have been reviewed to ensure they are accurate. Policies and Procedures have been reviewed regarding care plan development and review. See Attachment A.</p> <p>A mandatory in-service will be conducted on April 22, 2014 for all nursing staff. Care Plan Development and Review will be discussed. An in-service for dietary</p>	05/07/2014

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	<p>During an interview on 4/4/14, at 1:30 p.m., RN #8 provided no explanation as to why Resident #72 did not receive fruit with the meal.</p> <p>During review of physician orders, dated 3/11/14, Resident #72 was to have a dressing change completed daily on a g-tube site (gastrostomy tube site), as well as monitoring of the g-tube site for signs of infection with the dressing change. The g-tube was placed prior to Resident #72's admission, to assist with hydration, and increase nutritional intake.</p> <p>During an observation on 4/3/14 at 9:45 a.m., Resident #72 was resting in a bedside chair in his room. Resident #72's g-tube site was observed without a dressing in place over the site. During an additional observation on 4/3/14 at 1:45 p.m., Resident #72's g-tube site was again observed without a dressing in place over the site.</p> <p>During a dressing change observation on 4/4/14, at 10:00 a.m., RN #8 removed the blanket over Resident #72's lower body. Resident #72 was again observed to have no dressing in place over the g-tube site.</p> <p>During an interview on 4/4/14 at 10:05 a.m., RN #8 indicated not knowing why Resident #72 did not have a dressing in place over the site. RN #8 indicated it could have been due to Resident #72's scheduled shower.</p> <p>On 4/4/14, at 1:40 p.m., review of Resident #72's shower schedule, indicated Resident #72 preferred to have a shower after the evening meal. Resident #72 had last received a shower on 4/1/14, and was not</p>		<p>staff will be conducted on 4-22-14 and menu tickets and location of preferences will be reviewed.</p> <p>To ensure that this deficient practice does not re-occur DON or designee will monitor dressing changes by utilizing the QA tool Dressing Changes Review to ensure dressing changes are completed per physician orders weekly x 1 month, bi-weekly x 1 month, then monthly x 4 months and until determined resolved by the QA committee. See Attachment D. Dietary Manager or designee will monitor residents during meals to ensure that preferences are provided on meal tray utilizing QA tool Dietary Preference Review 2x weekly x 1 month, then 1x weekly x 1 month, then monthly x 4 months . See Attachment E. Any issues will be corrected immediately and logged on the QA summary log and reviewed and followed through the facility monthly QA meeting.</p> <p>Date of Compliance 5-7-14.</p>	

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F000312 SS=E	<p>scheduled to receive a shower again until 4/4/14, after the evening meal.</p> <p>3.1- 35(g)(2) 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the transfers of 4 residents, reliant on staff for transfers were preformed per facility policy for 4 of 4 residents reviewed for transfers. (#s 28,11,29 and 49)</p> <p>Findings include:</p> <p>1. On 4/1/14 at 3:45 p.m. a transfer of Resident #28 was observed. Certified Nursing Assistants (CNAs) #1 and #2 were observed transferring the resident to the bed. The CNAs held on to the resident with their arms under his arms and by the resident's pants.</p> <p>The clinical record of Resident #28 was reviewed on 4/7/14 at 1:20 p.m. The record indicated the resident's diagnoses included, but were not limited to, dementia, malaise, fatigue, Atrial Fibrillation, high blood pressure, and Diabetes.</p> <p>The Care Plan, dated 3/14/14, indicated Resident #28 required extensive assistance for all Activities of Daily Living. The Care Plan interventions included, staff assistance</p>	F000312	<p>F312 ADL Care Provided for Dependent Residents: It is the policy of Miller's Merry Manor, Hartford City for the residents to receive the necessary care and services needed for those unable to do their own ADL care independently.</p> <p>Resident's # 28, 11, 29, and 49 had no adverse effects as a result of this deficient practice.</p> <p>All residents have the potential to be affected by this deficient practice. An assessment for safe patient handling and movement is being completed on each resident who was not either a mechanical lift or an independent transfer per the therapy department to determine the most appropriate way to transfer each resident. See Attachment F.</p> <p>Policies and Procedures have been reviewed regarding gait belt use</p>				

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	<p>for transfers.</p> <p>The CNA assignment sheet indicated Resident #28 required a walker and one staff member assistance for transfers.</p> <p>Resident #28 was interviewed on 4/3/14 at 1:10 p.m. During the interview, the resident indicated he did not like staff to hold on to the back of his pants during transfers.</p> <p>The Physical Therapy Assistant (PTA) was interviewed on 4/7/14 at 10:00 a.m. During the interview, the PTA indicated Resident #28 was receiving physical therapy. The PTA indicated a gait belt should be used by staff for transfers instead of under the Resident's arms and by pulling on the back of his pants.</p> <p>2. On 4/3/14 at 10:20 a.m. a transfer with Resident #11 was observed. During the observation, Certified Nursing Assistant (CNA) and LPN #4 were observed transferring the resident from the bed to the wheelchair. The staff put their arms under the resident's arms, held the back of his pants, and assisted him to stand. With their arms still under the resident's arms and pulling the back of his pants, assisted the resident to the wheelchair.</p> <p>The clinical record of Resident #11 was reviewed on 4/3/14 at 8:20 am. The record indicated the resident's diagnoses included, but were not limited to terminal illness,vascular dementia, dysphasia, Benign Prostatic Hypertrophy, heart disease with a pacemaker and depressive disorder</p> <p>The Care Plan, dated 3/17/14, indicated Resident #11 required extensive staff assistance for transfers and was at risk for</p>		<p>procedure, transfer from bed to chair policy, transfer from chair to bed policy, stand-up lift policy, and mechanical lift policy. See Attachments G, H, I, J and K.</p> <p>A mandatory in-service will be conducted on April 22, 2014 for all nursing staff. The above policies will be reviewed at the in-service as well as the assessment for safe patient handling and movement so that staff is aware of the most appropriate way to transfer each resident. We will be having a check off and return demonstration of each nursing staff member in regards to transfers.</p> <p>To ensure that this deficient practice does not re-occur the In-service Director or designee will monitor transfers of 1 and 2 assist residents periodically weekly x 6 months and until determined resolved by the QA committee. See attachment L. Any issues noted will be corrected immediately and then logged on the QA summary log and reviewed and followed through the facility monthly QA meeting.</p> <p>Date of Compliance 5-7-14.</p>				

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	<p>falls due to confusion,dementia,and an unsteady gait.</p> <p>The CNA assignment sheets indicated Resident #11 was to be transferred with two staff.</p> <p>Resident #11 was interviewed on 4/3/14 at 1:00 p.m. During the interview, the resident indicated he does not like the back of his pants being used by staff for transfers. The resident indicated, "...it's the norm..." and he was getting used to it.</p> <p>The Physical Therapy Assistant (PTA) was interviewed on 4/7/14 at 10:00 a.m. During the interview, the PTA indicated Resident #11 was being seen by therapy. The PTA indicated Resident #11 required two staff to assist using a gait belt and a walker to assist with transfers. The PTA indicated it was difficult at times to transfer the resident with a gait belt because he was so tall, but staff should use a gait belt and not the back of pants.</p> <p>3. On 4/7/14 at 9:45 a.m. a transfer of Resident #29 was observed with Certified Nursing Assistants (CNAs) #3 and #5. The CNAs each put one arm under the resident's arms and the other hand, the staff used the back of the resident's pants to hold onto, pulling as they transferred. The CNAs assisted Resident #29 from the wheelchair to the recliner.</p> <p>The clinical record of Resident #29 was reviewed on 4/3/14 at 12:30 p.m. The record indicated the resident's diagnoses included, but were not limited to, dementia, depression, high blood pressure,syncope (dizziness), and stroke.</p>			

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	<p>The Care Plan, dated 3/12/14, indicated Resident #29 required extensive to total staff assistance for Activities of Daily Living and could be physically abusive to staff during care.</p> <p>The CNA assignment sheet indicated Resident #29 required one staff member and a gait belt for transfers.</p> <p>4. On 4/7/14 at 8:40 a.m. a transfer of Resident #49 was observed. Certified Nursing Assistant (CNA) #6 was observed transferring the resident from the toilet. The CNA held on to the resident by putting her arms under the resident's arms. CNA #6 assisted Resident #49 to stand and hold on to the grab bar in the bathroom. CNA #6 cleaned Resident #49 and assisted the resident to sit in the wheelchair. CNA #6 did not use a gait belt.</p> <p>The clinical record of Resident #49 was reviewed on 4/3/14 at 1:25 p.m. The record indicated the resident's diagnoses included, but were not limited to, complete rupture of the rotator cuff, joint pain, dysphasia, anxiety, depressive disorder, high blood pressure and atrial fibrillation.</p> <p>The Care Plan, dated 3/20/14, indicated Resident #49 required limited staff assistance with Activities of Daily Living due to weakness, arthritis, chronic shoulder pain, and right rotator cuff fracture.</p> <p>The CNA assignment sheet indicated Resident #49 required the assistance of one staff member and a gait belt for transfers.</p> <p>CNA #6 was interviewed on 4/7/14 at 10:25</p>			

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	<p>a.m. During the interview, the CNA indicated she knew the CNA assignment sheet indicated a gait belt was to be used when transferring Resident #49. CNA #6 indicated sometimes she uses a gait belt and sometimes she doesn't. The CNA indicated she did not use a gait belt to assist Resident #49 to transfer because the resident had not wanted the gait belt used yesterday.</p> <p>5. CNA #3 was interviewed on 4/7/14 at 11:00 a.m. During the interview, the CNA indicated CNA assignment sheets provided information about how to care for residents, including how much assistance the residents required for transfers. The CNA indicated the assignment sheets were accurate and updated on Tuesdays.</p> <p>The Inservice Nurse was interviewed on 4/7/14 at 12:45 p.m. During the interview, the Inservice Nurse indicated all nursing staff had received training on transfers in February 2014. She further indicated there was no return demonstration. The Inservice nurse indicated she helps staff with resident care at times, but does not observe nursing staff providing care on a regular basis.</p> <p>The Inservice Nurse presented the February 2014 "Resident Lifting and Transfers" inservice on 4/7/14 at 12:45 p.m. The Inservice Nurse indicated all nursing staff completed the training. The training provided the following information. "...A gait belt with handles should only be used when moving residents who are partially dependent, can bear some weight, and are cooperative. It should be used for transfers from bed to chair, chair to bed, or chair to car. It should also be used when repositioning residents in chairs and for</p>						

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F000329 SS=D	<p>supporting residents during walking... The goal of any transfer is to move a resident safely and easily while preventing injury to the resident and the worker..."</p> <p>The training did not include transferring using the back of a resident's pants or under a resident's arms.</p> <p>6. The facility policy, "Transfer from Bed to Chair", dated 3/1/2001, was presented by the Nurse Consultant on 4/7/14 at 1:00 p.m. The policy provided the following information.</p> <p>"...B. PROCEDURE:</p> <p>7. Assist resident to a sitting position on the side of the bed.</p> <p>8. Apply gait belt to waist if resident if resident requires weight bearing assist.</p> <p>9. Using gait belt- grasp sides of belt with both hands and assist resident to a standing position; pivot turn and sit resident in chair..."</p> <p>3.1-38(a)(2)(B) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that</p>						

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	<p>residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure indications for the use of psychoactive medications for 2 of 5 residents reviewed for unnecessary drugs. (Resident #s 49 and 29). The facility failed to ensure gradual dose reductions were completed for 1 of 5 residents reviewed for the use of unnecessary medications. (Resident #17).</p> <p>Findings Include:</p> <p>1. The clinical record of Resident #29 was reviewed on 4/3/14 at 12:30 p.m. The record indicated the resident's diagnoses included, but were not limited to, senile dementia with delirium, depressive disorder, and syncope (dizziness).</p> <p>The current physician orders included 20 milligrams (mgs) daily of the antidepressant, Lexapro, ordered on 9/13/13, and 0.5 mgs of the antipsychotic, Risperdal, twice daily for delirium with behavioral disturbances ordered on 3/3/14.</p> <p>The psychiatric traveling company Nurse Practitioner (NP) notes indicated on 1/16/14 "...three reports of resident being physical with staff..."</p>	F000329	<p>F329 Drug Regimen is free from unnecessary drugs: It is the policy of Millers Merry Manor, Hartford City to ensure that the resident's medication regimen helps promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being.</p> <p>Resident #29, 49, and 17 had no adverse effects as a result of this deficient practice. The above resident's have been reviewed by the interdisciplinary team and will continue to be reviewed to assure that medication therapy is based upon an adequate indication for use and that on-going monitoring of target behaviors will be documented as they occur in the clinical record along with interventions used to reduce and the results of the interventions. Each resident who the attending physician or psychiatrist feels as though a gradual dose reduction would be contraindicated will be thoroughly documented on. The documentation will include the clinical rationale for why any</p>	05/07/2014

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	<p>On 2/3/14, the NP note indicated "... Patient started on Risperdal after resisting care and hitting and scratching staff.</p> <p>On 3/5/14 the NP note indicated the resident was pleasant and to increase the Risperdal dosage.</p> <p>The Facility IDT evaluation, dated 2/3/14, indicated "New Behavior Tracking was opened this day for cussing at staff...NP in facility at this time, medication was ordered." The note made no mention of staff approach, monitoring of staff interactions, or updating interventions.</p> <p>The Care Plan, dated 3/12/14, included two "Behavior" Care Plans. The first indicated "Resident displays mood issues as exhibited by: anger at staff." The second indicated "Resident displays inappropriate physical behavioral issues as exhibited by: hitting, kicking, pinching staff."</p> <p>The Care Plan interventions included, medication administration and the documentation of the behaviors, assess for unmet needs, do not argue or reason, approach later, if resident becomes physical, remove self from situation and ensure safety, acknowledge concern and inform her it will be addressed.</p> <p>The facility "Behavior Tracking" indicated staff documented behaviors five days in January, ten days in February and three days in March 2014.</p> <p>The Psychologist's Nurse Practitioner (NP) was interviewed on 4/7/14 at 10:05 a.m. During the interview, the NP indicated the</p>		<p>additional attempted dose reductions at that time would be likely to impair the resident's function, increase distressing behavior or cause psychiatric instability by exacerbating an underlying psych disorder.</p> <p>All residents have the potential to be affected by this deficient practice. All residents on psychotropic medications have been reviewed to ensure there is a schedule for gradual dose reductions in place. The facility's psych provider has been educated on F329 regulation and survey citation. Family members will be educated on medication reductions guidelines during care plan meetings as needed. We will continue to use the Summary of OBRA psychoactive and hypnotic regulations to assess for appropriate indications and ongoing need of psychotropic medications.</p> <p>Policies and Procedures have been reviewed regarding psychotropic drug use. See Attachment M.</p> <p>DON, SSD, MDS coordinator, and ADON have reviewed the policies regarding psychotropic drug use as well as the psychoactive and sedative/hypnotic utilization report which is generated by the pharmacy consultant monthly. All resident's who have a psychotropic medication will be tracked per this report with the "next evaluation" field which is</p>	

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	<p>facility tried redirection for a month or so. She indicated Resident #29 had scratched a staff member across her eye, so the resident was put back on risperdal for psychosis with delusions, used to curve behaviors. The NP indicated Resident #29 was prescribed the antipsychotic because she was a threat to staff.</p> <p>The facility's Nurse Consultant was interviewed on 4/7/14 at 12:05 p.m. During the interview, the Nurse Consultant indicated the medication was prescribed for Resident #29 because the resident hit staff.</p> <p>The Social Service Director (SSD) was interviewed on 4/7/14 at 10:35 a.m. During the interview the SSD, she indicated she did inservices with staff concerning residents with dementia.</p> <p>The Inservice Nurse was interviewed on 4/7/14 at 12:45 p.m. During the interview, the Inservice Nurse presented a computerized training entitled "Therapeutic Activity Programming for Persons with Dementia". The Inservice Nurse indicated all staff completed the training.</p> <p>2. The clinical record of Resident # 49 was completed on 4/3/14 at 1:25 p.m. The record indicated the resident's diagnoses included, but were not limited to, complete rupture of the rotator cuff, joint pain, anxiety, and depressive disorder.</p> <p>The physician orders included a telephone order, dated 1/30/14, for the antianxiety, Buspar to be given three times a day for generalized anxiety disorder.</p> <p>There was no physician progress note or</p>		<p>when the next formal assessment of the medication is due. A mandatory in-service will be conducted on April 22, 2014 in which the psychotropic drug use policy will be discussed. An in-service on staff approach and staff interactions will also be conducted at the mandatory in-service.</p> <p>The facility will continue to conduct monthly behavior meetings with SSD, DON, ADON, MDS coordinator, consultant pharmacists, and psych services. During this time all residents receiving psychoactive medications will be reviewed to ensure there is a schedule for gradual dose reductions in place. We will continue to use the Summary of OBRA psychoactive and hypnotic regulations to assess for appropriate indications and ongoing need of psychotropic medications.</p> <p>To ensure that this deficient practice does not re-occur SSD or her designee will monitor all residents with psychotropic drug use through the Behavior and Antipsychotic Medication Review and the Sedative/Hypnotic Drug Review QA tools weekly x 1 month, bi-monthly x 1 month, and monthly x 4 months and then quarterly thereafter. See Attachment N and O. Any issues noted will be corrected immediately and then concerns will be logged on the QA summary log and reviewed and followed through the facility</p>	

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	<p>nursing note dated 1/30/14 related to the medication.</p> <p>A telephone order, dated 1/16/14, indicated ten milligrams (mgs) of the antidepressant Lexapro daily for depression. This dosage was increased from it's original five mgs daily ordered on 3/30/13 .</p> <p>The clinical record indicated Resident #49 was seen by a Nurse Practioner and psychiatrist from a traveling psychiatric company. The company's notes provided the following information:</p> <p>A note, dated 11/5/13, indicated Resident #49 was depressed about living in the facility and that she was unable to do things for herself. The note indicated the resident could benefit from someone explaining her pain and organization process to her more closely.</p> <p>A note, dated 1/16/14, indicated staff reported Resident #49 had five episodes of excessive nervousness in November and two in October. The note indicated the resident was upset because she had to move across the hall for a short period. The resident did move back to her own room, then asked to move again because the resident's roommate was terminally ill and under Hospice care. The note indicated Resident #49 did not want to move out of her room and was concerned about the security of her personal belongings. The note further indicated the resident was upset about facility placement.</p> <p>A note, dated 2/3/14, indicated only the increase in both the Lexapro and buspar, no assessment or other interventions tried.</p>		<p>monthly QA meeting.</p> <p>Date of Compliance 5-7-14.</p>		

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	<p>The Care Plan, dated 3/20/14, indicated Resident #49 was depressed due to a loss of independence. The interventions included medications, monitoring of medications side effects, update the physician, encourage loved ones to visit, psychiatric services as needed.</p> <p>The "Behavior Tracking Record" was a tool used by staff to document behaviors through the care plan. The record was presented by the administrator on 4/4/14 at 1:40 p.m. The tracking record indicated Resident #49 displayed nervousness and or restlessness only two days in March, three days in February, and one day in January.</p> <p>The tracking form or the Care Plan indicated no change in interventions. The Care Plan made no mention of the reasons for the resident's depression.</p> <p>The Psychologist's Nurse Practioner (NP) was interviewed on 4/7/14 at 10:05 a.m. The NP indicated the facility had made attempts to use other interventions prior to the medication use. The NP was unaware as to where the interventions were documented.</p> <p>Certified Nursing Assistant (CNA) #6 was interviewed on 4/7/14 at 10:25 a.m. During the interview, CNA #6 indicated the resident has never hit, scratched, or refused care with her. The CNA indicated the resident had never cussed or yelled at her. The CNA indicated the resident liked her because she took her time with the resident and talked with her. The CNA indicated she had observed the resident hit other staff.</p> <p>The facility's Nurse Consultant was</p>						

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	<p>interviewed on 4/7/14 at 12:05 p.m. During the interview, the Nurse Consultant indicated the buspar was prescribed for Resident #49 because the resident hit staff.</p> <p>The Social Service Director (SSD) was interviewed on 4/7/14 at 10:35 a.m. During the interview the SSD, she did "approach" inservices with staff.</p> <p>The Inservice Nurse was interviewed on 4/7/14 at 12:45 p.m. During the interview the Inservice Nurse presented a computerized training entitled "Therapeutic Activity Programming for Persons with Dementia". The Inservice Nurse indicated all staff completed the training. The Inservice Nurse indicated CNA #6 worked with Resident #49 full time.</p> <p>3. The clinical record for Resident #17 was reviewed on 4/3/14 at 9:15 a.m. Current diagnoses included, but were not limited to, protein-calorie malnutrition, congestive heart failure, chronic obstructive pulmonary disease, dementia with behavioral disturbances, anxiety state, rheumatoid arthritis, essential hypertension, depressive disorder, debility and insomnia.</p> <p>The resident was currently receiving the following medications, on a daily basis Celexa (Antidepressant) originally ordered on 6/5/2010 and Ambien (Hypnotic) originally ordered on 3/29/11.</p> <p>The chart indicated a GDR (Gradual Dose Reduction) on Celexa, being used as an antidepressant was last completed on 2/14/11. The chart indicated no GDR was completed on Ambien since order date. A</p>			

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	<p>contraindication note for Celexa and Ambien was last completed on 12/22/11 and 3/13/14.</p> <p>During an interview with the Nurse Consultant on 4/4/14 at 2:16 p.m., she indicated no attempts or reductions in Celexa had been completed since 2/14/11 and no attempts or reductions in Ambien had been completed. The Nurse Consultant indicated the family of Resident #17 refused to have any reductions in the resident's medications.</p> <p>During an interview with the Director of Nursing on 4/7/14 at 12:50 p.m., she indicated GDR's were not attempted on Resident #17's Ambien or Celexa due to family request since 2011.</p> <p>No further documentation was provided by the facility as of exit 4/7/14.</p> <p>A review of Ambien in the "Nursing 2014 Drug Handbook" by Lippincott Williams & Wilkins dated 2014 on 4/8/14 at 11:20 a.m. indicated:</p> <p>"...Nursing Considerations:</p> <p>...Use drug only for short-term management of insomnia, usually 7-10 days."</p> <p>A review of the policy titled "Psychotropic Drug Use" dated 2/4/2008 was provided by the Nurse Consultant on 4/4/14 at 11:45 a.m. indicated the following:</p> <p>"Psychotropic Drug Use:</p> <p>Purpose: To ensure that medication regimen helps promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being...each resident</p>			

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	<p>receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s); nonpharmacological interventions are considered and used when indicated, instead of, or in addition to, medication; Clinically significant adverse consequences are minimized; and the potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate. Psychotropic medications will only be used when medically indicated to treat a specific condition. Gradual Dose Reductions (GDR) will be attempted...in an effort to discontinue these drugs. Ongoing monitoring will be in place to assess risks vs. benefits of continued medication use and psychotropic medications will not be used as a restraint...</p> <p>Procedure:</p> <p>1. The facility will assure that medication therapy is based upon an adequate indication for use by documenting the supporting diagnosis/indication of use at the time the order for psychotropic medication is obtained/received.</p> <p>3. ...Sedative/Hypnotic: ...Reduction Requirements: Quarterly reductions if used routinely (>50% of days in the month) and if used beyond the manufacture recommendations for duration of use. ...Periodic Review: ...Quarterly review by IDT (Interdisciplinary Team) to include evaluating and planning for reductions, evaluating non-med interventions and evaluating the effectiveness of the medication to help promote or maintain the highest practicable mental, physical and psychosocial well-being.</p>			

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F000441 SS=D	<p>4. ...Antidepressant: ...Periodic Review: Quarterly review by IDT to include evaluating and planning for reductions, evaluating non-med interventions and evaluating the effectiveness of the medication to help promote or maintain the highest practicable mental, physical and psychosocial well-being..."</p> <p>3.1-48(a)(4) 3.1-48(b)(2) 483.65</p> <p>INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <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</p>			

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	<p>disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure "modified contact isolation precautions" being implemented were clearly defined for 1 of 1 residents in contact isolation (Resident #15).</p> <p>Findings include:</p> <p>During the initial tour on 4/1/14 at 9:15 a.m., Resident #15 was observed receiving physical therapy from the physical therapist in the therapy room.</p> <p>During an observation on 4/1/14 at 11:10 a.m., Resident #15 was sitting in her wheelchair in her room visiting with her daughter. Resident #15's door to her room had signs displayed indicating to see the nurse before entering. During an interview with LPN #7 on 4/1/14 at 11:10 a.m., she indicated Resident #15 was on "modified contact isolation precautions" for possible Clostridium Difficile infection (a bacterial infection). She indicated the "modified contact isolation precautions" were for residents which the infection was contained so they could come out of their room for dining, therapy and activities.</p> <p>During a dining observation in the main</p>	F000441	<p>F441 Infection Control: It is the policy of Miller's Merry Manor, Hartford City to establish and maintain an infection control and prevention program to prevent the spread of infectious or communicable diseases. Isolation techniques will be initiated based upon the status of an infectious organism and the location of the isolate with the overall goal of the isolation process focusing on the isolation of the organism, not the individual resident.</p> <p>Resident #15 had no adverse effects as a result of this deficient practice. The resident's organism remained isolated throughout the treatment.</p> <p>All resident's have the potential to be affected by this deficient practice. Due to the fact that the possible infectious organism remained isolated no issues were identified.</p> <p>Policies and Procedures have been reviewed regarding Infection</p>	05/07/2014			

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	<p>dining area on 4/1/14 at 12:00 p.m., Resident #15 was brought down to the main dining area in her wheelchair by her daughter and placed at a table with three other residents.</p> <p>The clinical record of Resident #15 was reviewed on 4/3/14 at 8:25 a.m. The record indicated the resident's diagnoses included, but were not limited to, Spinal Stenosis, Osteoporosis, abnormality of gait and syncope and collapse.</p> <p>Resident #15 had an active Physician order for "modified contact Isolation" dated 3/21/14 at 10:45 a.m. The order did not define what the modification to the contact isolation was.</p> <p>The facility policies "Colonized Organism", "Transmission-based Precautions:" and "Transmission-based precautions room set-up", dated 5/30/06 and provided by the Director of Nursing on 4/3/14 at 8:45 a.m., did not provide a definition for "modified contact isolation."</p> <p>During an interview with the Nurse Consultant on 4/4/14 at 11:00 a.m., the concern of the term "modified contact isolation" not being defined in a policy or a Physician order was expressed to her. The Nurse Consultant indicated the modified contact isolation orders were supposed to have been changed to show they were used for residents that had the infection contained and the resident was continent of bowel and bladder to allow the resident to leave their room. The Nurse Consultant indicated that she could not find this definition or order in Resident #15's Physician orders or in a policy.</p> <p>3.1-18(b)(2)</p>		<p>Control. See Attachment P.</p> <p>A mandatory in-service will be conducted on April 22, 2014 for all nursing staff. Infection Control will be discussed with a focus on isolation and the goal of the isolation process focusing on the isolation of the organism, not the individual resident. Any variation from the current policy will have specific physicians orders.</p> <p>To ensure that this deficient practice does not re-occur DON or designee will monitor all residents on isolation techniques weekly x 1 month, bi-weekly x 1 month, then monthly x4 months and quarterly thereafter. Any issues will be corrected immediately and then logged on the QA summary log and reviewed and followed through the facility monthly QA meeting. See Attachment Q.</p> <p>Date of Compliance 5-7-14.</p>				

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F000498 SS=E	<p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS</p> <p>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistants performed transfers according to their policy for 4 residents who relied on staff for transfers during 4 of 4 observations of resident transfers. (Residents #'s 28,11, 29 and 49) (CNA #'s 1, 2, 3, 5, and 6)</p> <p>Findings include:</p> <p>1. On 4/1/14 at 3:45 p.m. a transfer of Resident #28 was observed. Certified Nursing Assistants (CNAs) #1 and #2 were observed transferring the resident to the bed. The CNAs held on to the resident with their arms under his arms and by the resident's pants.</p> <p>The clinical record of Resident #28 was reviewed on 4/7/14 at 1:20 p.m. The record indicated the resident's diagnoses included, but were not limited to, dementia, malaise, fatigue, Atrial Fibrillation, high blood pressure and Diabetes.</p> <p>The Care Plan, dated 3/14/14, indicated Resident #28 required extensive assistance for all Activities of Daily Living. The Care Plan interventions included, staff assistance for transfers.</p>	F000498	<p>F498 Proficiency of Nurse Aides- demonstrate competency to care for resident's needs: It is the policy of Miller's Merry Manor, Hartford City to ensure Certified Nursing Assistants perform tasks according to our policies.</p> <p>Resident's # 28, 11, 29, and 49 had no adverse effects as a result of this deficient practice.</p> <p>All residents have the potential to be affected by this deficient practice. An assessment for safe patient handling and movement is being completed on each resident who was not either a mechanical lift or an independent transfer per the therapy department to determine the most appropriate way to transfer each resident. See Attachment F.</p> <p>Policies and Procedures have been reviewed regarding gait belt use procedure, transfer from bed to chair policy, transfer from chair to bed policy, stand-up lift policy, and mechanical lift policy. See</p>	05/07/2014

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	<p>The CNA assignment sheet indicated Resident #28 required a walker and one staff member assistance for transfers.</p> <p>Resident #28 was interviewed on 4/3/14 at 1:10 p.m. During the interview, the resident indicated he did not like staff to hold on to the back of his pants during transfers.</p> <p>The Physical Therapy Assistant (PTA) was interviewed on 4/7/14 at 10:00 a.m. During the interview, the PTA indicated Resident #28 was receiving physical therapy. The PTA indicated a gait belt should be used by staff for transfers instead of under the Resident's arms and by pulling on the back of his pants.</p> <p>2. On 4/3/14 at 10:20 a.m. a transfer with Resident #11 was observed. During the observation, Certified Nursing Assistant (CNA) #5 and LPN #4 were observed transferring the resident from the bed to the wheelchair. The staff put their arms under the resident's arms, held the back of his pants, and assisted him to stand. With their arms still under the resident's arms and pulling the back of his pants, the staff assisted the resident to the wheelchair.</p> <p>The clinical record of Resident #11 was reviewed on 4/3/14 at 8:20 am. The record indicated the resident's diagnoses included, but were not limited to Terminal illness,vascular dementia, dysphasia, Benign Prostatic Hypertrophy, heart disease with a pacemaker,and depressive disorder</p> <p>The Care Plan, dated 3/17/14, indicated Resident #11 required extensive staff assistance for transfers and was at risk for falls due to confusion,dementia,and an</p>		<p>Attachments G, H, I, J and K.</p> <p>A mandatory in-service will be conducted on April 22, 2014 for all nursing staff. The above policies will be reviewed at the in-service as well as the assessment for safe patient handling and movement so that staff is aware of the most appropriate way to transfer each resident. We will be having a check off and return demonstration of each nursing staff member in regards to transfers.</p> <p>To ensure that this deficient practice does not re-occur the In-service Director or designee will monitor transfers of 1 and 2 assist residents periodically weekly x 6 months and until determined resolved by the QA committee. See attachment L. Any issues noted will be corrected immediately and then logged on the QA summary log and reviewed and followed through the facility monthly QA meeting.</p> <p>Date of Compliance 5-7-14.</p>	

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	<p>unsteady gait.</p> <p>The CNA assignment sheets indicated Resident #11 was to be transferred with two staff.</p> <p>Resident #11 was interviewed on 4/3/14 at 1:00 p.m. During the interview, the resident indicated he does not like the back of his pants being used by staff for transfers. The resident indicated, "...it's the norm..." and he was getting used to it.</p> <p>The Physical Therapy Assistant (PTA) was interviewed on 4/7/14 at 10:00 a.m. During the interview the PTA indicated Resident #11 was being seen by therapy. The PTA indicated Resident #11 required two staff to assist using a gait belt and a walker to assist with transfers. The PTA indicated it was difficult at times to transfer the resident with a gait belt because her was so tall, but staff should use a gait belt and not the back of pants</p> <p>3. On 4/7/14 at 9:45 a.m. a transfer of Resident #29 was observed with Certified Nursing Assistants (CNAs) #3 and #5. The CNAs each put one arm under the resident's arms and the other hand, the staff used to hold on to the back of the resident's pants, pulling as they transferred. The CNAs assisted Resident #29 from the wheelchair to the recliner.</p> <p>The clinical record of Resident #29 was reviewed on 4/3/14 at 12:30 p.m. The record indicated the resident's diagnoses included, but were not limited to, dementia, depression, high blood pressure, syncope (dizziness), and stroke.</p>						

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	<p>The Care Plan, dated 3/12/14, indicated Resident #29 required extensive to total staff assistance for Activities of Daily Living and could be physically abusive to staff during care.</p> <p>The CNA assignment sheet indicated Resident #29 required one staff member and a gait belt for transfers.</p> <p>CNA #3 was interviewed on 4/7/14 at 11:00 a.m. During the interview, the CNA indicated CNA assignment sheets provided information about how to care for residents, including how much assistance the residents required for transfers. The CNA indicated the assignment sheets were accurate and updated on Tuesdays.</p> <p>4. On 4/7/14 at 8:40 a.m. a transfer of Resident #49 was observed. Certified Nursing Assistant (CNA) #6 was observed transferring the resident from the toilet. The CNA held on to the resident by putting her arms under the resident's arms. CNA #6 assisted Resident #49 to stand and hold on to the grab bar in the bathroom. CNA #6 cleaned Resident #49 and assisted the resident to sit in the wheelchair. CNA #6 did not use a gait belt.</p> <p>The clinical record of Resident #49 was reviewed on 4/3/14 at 1:25 p.m. The record indicated the resident's diagnoses included, but were not limited to, complete rupture of the rotator cuff, joint pain, dysphasia, anxiety, depressive disorder, high blood pressure and atrial fibrillation.</p> <p>The Care Plan, dated 3/20/14, indicated Resident #49 required limited staff assistance with Activities of Daily Living due</p>			

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	<p>to weakness, arthritis, chronic shoulder pain, and right rotator cuff fracture.</p> <p>The CNA assignment sheet indicated Resident #49 required the assistance of one staff member and a gait belt for transfers.</p> <p>CNA #6 was interviewed on 4/7/14 at 10:25 a.m. During the interview, the CNA indicated she knew the CNA assignment sheet indicated a gait belt was to be used when transferring Resident #49. CNA #6 indicated sometimes she uses a gait belt and sometimes she doesn't. The CNA indicated she did not use a gait belt to assist Resident #49 to transfer because the resident had not wanted the gait belt used yesterday.</p> <p>5. CNA #3 was interviewed on 4/7/14 at 11:00 a.m. During the interview, the CNA indicated CNA assignment sheets provided information about how to care for residents, including how much assistance the residents required for transfers. The CNA indicated the assignment sheets were accurate and updated on Tuesdays.</p> <p>The Inservice Nurse was interviewed on 4/7/14 at 12:45 p.m. During the interview, the Inservice Nurse indicated all nursing staff had received training on transfers in February 2014. She further indicated there was no return demonstration. The Inservice nurse indicated she helped staff with resident care at times, but did not observe nursing staff providing care on a regular basis.</p> <p>The Inservice Nurse presented the February 2014 "Resident Lifting and Transfers" inservice on 4/7/14 at 12:45 p.m. The Inservice Nurse indicated all nursing staff completed the training. The training provided</p>			

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F000520 SS=D	<p>the following information.</p> <p>"...A gait belt with handles should only be used when moving residents who are partially dependent, can bear some weight, and are cooperative. It should be used for transfers from bed to chair, chair to bed, or chair to car. It should also be used when repositioning residents in chairs and for supporting residents during walking... The goal of any transfer is to move a resident safely and easily while preventing injury to the resident and the worker..."</p> <p>The training did not include transferring using the back of a resident's pants and under a resident's arms.</p> <p>6. The facility policy, "Transfer from Bed to Chair", dated 3/1/2001, was presented by the Nurse Consultant on 4/7/14 at 1:00 p.m. The policy provided the following information.</p> <p>"...B. PROCEDURE:</p> <p>7. Assist resident to a sitting position on the side of the bed.</p> <p>8. Apply gait belt to waist if resident if resident requires weight bearing assist.</p> <p>9. Using gait belt- grasp sides of belt with both hands and assist resident to a standing position; pivot turn and sit resident in chair..."</p> <p>3.1-14(h) 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</p>			

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	<p>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.</p> <p>Based on observation, interview and record review, the facility Quality Assessment and Assurance Committee (QAA) failed to identify a deficient practice regarding clearly defining "modified contact isolation precautions" being implemented for 1 of 1 residents in contact isolation (Resident #15).</p> <p>Findings include:</p> <p>During an interview on 4/7/14 at 2:00 p.m., the Director of Nursing and Minimum Data Set Assessment (MDS) Nurse were interviewed regarding QAA (Quality Assurance and Assessment) and the identified concern of the annual survey as follows:</p> <p>1. The facility failed to clearly define "modified contact isolation precautions" being implemented for 1 of 1 residents in contact</p>	F000520	<p>F520 Quality Assessment and Assurance: It is the policy of Miller's Merry Manor, Hartford City to identify areas in need of improvement in resident care.</p> <p>Resident #15 had no adverse effects as a result of this deficient practice. The DON had identified a deficient practice in regards to clearly defining modified contact isolation precautions, although it was not identified prior to annual state licensure survey.</p> <p>Any resident placed in modified contact isolation precautions would have the potential to be affected by this deficient practice. The facility has no other residents with a physicians order for modified</p>	05/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/07/2014
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 0548 S 100 W HARTFORD CITY, IN 47348		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	isolation. The Director of Nursing indicated that this concern had not been included in the facility QAA program. 3.1-52(b)(2)		contact isolation precautions therefore no other issues were identified. Policies and Procedures have been reviewed regarding Quality Assessment/Improvement Program policy with DON and QA program director. See attachment R. To ensure that this deficient practice does not re-occur DON or designee will monitor that each identified deficient practice will be monitored through the facility QA program and noted in the QA minutes. Date of Compliance 5-7-14.		