

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155574	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WALKERTON TR WALKERTON, IN 46574
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: June 2, 3, 4, 5, 6, 9, and 10, 2014</p> <p>Facility Number: 000431 Provider Number: 155574 AIM Number: 100290380</p> <p>Survey Team: Julie Baumgartner, RN-TC Shauna Carlson, RN Pam Williams, RN</p> <p>Census Bed Type: SNF: 6 SNF/NF: 62 Total: 68</p> <p>Census by Payor Type: Medicare: 4 Medicaid: 56 Other: 8 Total: 68</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on June 18, 2014, by Brenda Meredith, R.N.</p>	F000000	<p>The Walkerton facility respectfully requests paper compliance. Please accept the following plan of correction for the following F-Tags as our credible allegation of compliance.</p>	
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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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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>			

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	<p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse to the Administrator and the appropriate state agencies. This affected 1 of 2 allegations of abuse reviewed.</p> <p>Findings include:</p> <p>On 6-9-2014 at 11:15 A.M., interview with Resident #118 indicated that he had reported that "...a nurse had grabbed his wrist during care and it hurt his arm...I went to the SSD [Social Service Director] and told her about it...."</p> <p>On 6-9-2014 at 11:53 A.M., interview with SSD indicated "...he [Resident #118] came into my office and told me that LPN #4 [Licensed Practical Nurse] had grabbed his wrist...I told the DON [Director of Nursing] about it because I felt it was a nursing issue...I did not report it to the Administrator...."</p> <p>Interview at this time with the Administrator indicated, "...they [staff] need to report [allegations of abuse] to their supervisor and then to the DON or myself...the DON reports to the state and then I follow up with the investigation...the DON may have reported it and did her own</p>	F000225	<p>It is the policy of Miller's Merry Manor, Walkerton that all residents have the right to be free from abuse of all forms. Miller's Merry Manor has policies and procedures in place that ensures that all alleged violations are reported immediately to the Administrator of the facility and to other officials in accordance with state law through established procedures (including to the state survey and certification agency). The allegation for resident #118 was called into the SDOH on 6/9/2014 and the follow up was sent on 6/13/2014. The surveyors were aware of this and the documents were provided to them. All residents are at risk to be affected by the deficient practice. To insure that this finding does not recur, an in-service education program will be given to all staff on 6/26/2014, 6/30/2014, 7/02/2014 and 7/03/2014 over the entire abuse policy, when to report abuse, who to report abuse to and reasonable suspicion of a crime. All staff will be inserviced on properly reporting all allegations of abuse and mistreatment immediately to the administrator and the allegation will be called into the SDOH with a complete investigation to follow. Monitoring of the effectiveness of this will</p>	07/10/2014			

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	<p>investigation...if it was cleared up between the resident and the nurse, it may not have gotten reported...I am not sure of our policy...."</p> <p>On 6-9-2014 at 1:50 P.M., interview with the DON indicated "...I was notified about the residents allegation from the SSD on 6-4-2014...I started an investigation and went to talk to the resident about the incident...he [Resident #118] seemed more upset about the care of his PICC [Peripherally Inserted Central Catheter] line...that was entirely my fault [for not reporting the incident]...."</p> <p>On 6-9-2014 at 2:00 P.M., review of the "Abuse Investigation Worksheet," received on 6-9-2014 at 1 P.M. from the Administrator, indicated "...Date of incident: May 31st...Resident Involved: [Resident #118's name]...Other party involved...Staff: [LPN #4's name]...Description of Allegation: The nurse was rough c [with] my arm...Allegation reported by:[SSD's name]...Date:6-4-2014 ...Time:4 PM...."</p> <p>In the body of the investigation, review of the DON statement indicated, "6/4/14... [SSD's name] came to me and said when she was talking to him that he reported the nurse [LPN #4's name] had been rough c [with] him while trying to work</p>		<p>be completed daily by reviewing the 24 hour condition report on a daily basis X 2 weeks, then weekly X 4 weeks and then monthly thereafter and will be summarized on a QA tool titled "24 Hour Condition Review" (Attachment A). Any identified issues will be addressed immediately. Concerns/Issues will be logged on the QA Summary Problem Log (Attachment B) and reviewed/revised monthly at the facility QA meeting. Date of compliance 7/10/2014.</p>		

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	<p>on the PICC line." Also in the body of the investigation was a statement from the Administrator indicating she had spoken to Resident #118 about this incident on 6-5-2014.</p> <p>On 6-9-2014 at 2:10 P.M., review of the "Abuse Prohibition, Reporting, and Investigation" policy start date 2-22-2013, received from the Administrator on 6-9-2014 at 12:25 P.M., indicated "...1...C. [Facility Name] has policies and procedures in place that ensures that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)...4...A. The facility Administrator is designated as the individual responsible for coordinating all efforts in investigation of abuse allegations, and for assuring that all policies and procedures are followed...C. Violations of the aforementioned will be reported to the Long Term Care Division of the Indiana State Department of Health [ISDH] and other officials in accordance with state law though established procedures as outlined in the 'Incident</p>			

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F000226 SS=D	<p>Reporting to the ISDH' procedure...."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement the abuse policy and procedure by not ensuring staff were knowledgeable related to what constitutes abuse for 4 out of 8 employees (Certified Nursing Assistants #13 and #15, Licensed Practical Nurse #4, Registered Nurse #14) and when to report alleged abuse for 3 of 8 employees (Administrator, Social Service Director, Licensed Practical Nurse #4)</p> <p>Findings include:</p> <p>On 6-9-2014 at 11:53 A.M., an interview with the Administrator indicated, "...they [staff] need to report [allegations of</p>	F000226	<p>It is the policy of Miller's Merry Manor Walkerton that a system and policies are in place that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. This policy is in accordance with State and Federal Law. The allegation for resident #118 was called into the SDOH on 6/9/2014 and the follow up was sent on 6/13/2014. The surveyors were aware of this and the documents were provided to them. Identified employee was subsequently counseled and suspended during the investigative process. Determination was made through a thorough interview of the resident that the "allegation of</p>	07/10/2014			

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	<p>abuse] to their supervisor and then to the DON [Director of Nursing] or myself...the DON reports to the state and then I follow up with the investigation...the DON may have reported it and did her own investigation...if it was cleared up between the resident and the nurse, it may not have gotten reported...I am not sure of our policy...."</p> <p>Interview with Social Services Director at this time indicated "...if it's a nursing issue, I would report it to the DON...."</p> <p>On 6-9-2014 at 2:24 P.M., an interview with CNA #13 indicated "...physical, verbal, sexual, mental, and misappropriation...." as the types of abuse.</p> <p>On 6-9-2014 at 2:33 P.M., an interview with LPN #4 indicated "...physical, mental, financial, privacy, dignity, and withholding treatment...." She also indicated in a scenario of overhearing verbal abuse she would, "...ask the resident who it was, ask her [the resident] if she thought it was serious enough that I should report it to my boss...if it was just once...maybe it was a misunderstanding? Maybe I would watch that aide very closely...if the aide went into the room again, I would maybe watch her</p>		<p>abuse" could not be substantiated. This resident has been discharged from the facility since, without any adverse effects of the occurrence. The deficient practice has the potential to affect all residents in the building. To insure that this finding does not recur, an in-service education program was given to all staff on 6/26/2014, 6/30/2014, 7/02/2014 and 7/03/2014 regarding the entire policy, abuse, when to report abuse, who to report abuse to and reasonable suspicion of a crime as well as the seven forms of abuse. Monitoring of the effectiveness of this will be completed daily by reviewing the 24 hour condition report on a daily basis X 2 weeks, then weekly X 4 weeks and then monthly thereafter and will be summarized on the QA Tool "24 Hour Condition Report Review". (Attachment A) Any identified issues will be addressed immediately. Concerns/issues will be logged on the QA Summary Problem Log (Attachment B) and reviewed/revised monthly at the facility QA meeting. Date of compliance 7/10/2014.</p>				

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	<p>closer...."</p> <p>On 6-9-2014 at 2:58 P.M., interview with RN #14 indicated "...mental, sexual, misappropriation of funds, seclusion, physical, and verbal...." as types of abuse.</p> <p>On 6-9-2014 at 3:11 P.M., interview with CNA #15 indicated "...isolation, inappropriation [sic] of funds, verbal, sexual, and mental...." as types of abuse.</p> <p>On 6-9-2014 at 3:30 P.M., review of the "Abuse Prohibition, Reporting, and Investigation" policy, start date 2-22-2013, received from the Administrator on 6-9-2014 at 12:25 P.M., indicated "...1....A. It is the policy of [facility name] that all residents have the right to be free from verbal, sexual, physical...mental abuse...involuntary seclusion...neglect...misappropriation of resident property...C. [Facility name] has policies and procedures in place that insures that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility...."</p> <p>3.1-28(a)</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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, interview and record review, the facility failed to ensure 1 resident's privacy and dignity was protected related to knocking before entering the room, in a sample of 9 residents observed for medication pass. (Resident #117)</p> <p>Findings include:</p> <p>On 6-6-14 at 5:22 A.M., LPN (Licensed Practical Nurse) #4 was observed to be preparing morning medications for the roommate of Resident #117. The door to this resident's room was shut at this time. LPN #4 was observed to open the door and enter the room without knocking and waiting for a response, turned on the light and indicated to Resident #117's roommate (bed 2- by the window) "...I have your pills for you...." Resident #117 was observed laying in bed 1 (by the</p>	F000241	<p>It is the polciy of Miller's Merry Manor Walkerton to promote care for the residents in an enviornment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Resident #117 and his roommate were apologized to for staff not knocking while entering their room and for turning on the light the morning of 6/6/2014. Resident #117 accepted the apology. This deficient practice has the potential to affect all residents in the building. To insure that this finding does not recur, an in-service education program was given to all staff on 6/26/2014, 6/30/2014, 7/02/2014 and 7/03/2014 regarding resident rights and dignity, specifically highlighting knocking before entering resident rooms and professional courtesy. The facility will use a QA tool "Quality of Life-Dignity Review" (Attachment</p>	07/10/2014

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	<p>door) squinting from the light before rolling to his left side and covering his head with the sheet. LPN #4 left the room to gather supplies to do a blood sugar on bed 2 and an interview was conducted at this time with Resident #117. Resident #117 indicated he was sleeping until the light just got turned on, "...It ain't right. I ain't got rest since I've been here...about 2 weeks...this happens a lot..." LPN #4 returned to the room and checked the blood sugar of Resident #117's roommate before turning off the light and exiting the room without shutting the door.</p> <p>On 6-6-14 at 5:31 A.M., LPN #4 was observed preparing morning medications for a resident while standing at her medication cart outside of the room of Resident #117. Resident #117 was observed to stand up from his bed, walk over to his room door, and use his walker to shut the door.</p> <p>On 6-9-14 at 10:00 A.M., interview with the DON (Director of Nursing) indicated they did not have a policy related to knocking on the door but everyone should do it before entering a resident's room. The DON indicated at this time the facility used their residents' rights orientation information as guidelines. Review at this time of the "Millers Merry Manor - Residents' Rights" orientation</p>		<p>C). The in-service director and nurse managers will be responsible for completing the tool daily for 2 weeks, weekly for 4 weeks then monthly thereafter. Any identified issues will be addressed immediately. Concerns/issues will be logged on the QA SUMmary Problem Log (Attachment B) and reviewed/revised monthly at the facility QA meeting to ensure ongoing compliance. Date of compliance 7/10/2014.</p>				

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F000282 SS=D	<p>information, received from the DON, indicated "...Objectives:...describe four ways to protect residents' rights...To protect the resident's right to privacy...One easy way to protect this right is to always knock before entering a resident's room (even if the door is open). After you knock, wait for a response from the resident and ask permission to enter. If the resident does not respond, state your name and intent to enter the room before proceeding...."</p> <p>3.1-3(t)</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, interview, and record review, the facility failed to ensure the plan of care was followed as written related to providing house supplements for 1 out of 3 residents reviewed for nutrition. (Residents #53)</p>	F000282	It is the policy of Miller's Merry Manor Walkerton that service provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care. Resident # 53 is receiving his nutritional supplements (house	07/10/2014			

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	<p>Findings include:</p> <p>On 6/5/14 at 9:35 A.M., review of the clinical record for Resident #53 was conducted. Resident 53's diagnoses included, but were not limited to, "...depressive disorder not elsewhere classified, unspecified, peripheral vascular disease, paralysis agitans, atrial fibrillation, diab w/o comp type II / uns not stated unctrl [diabetes without complication type II unspecified not stated as uncontrolled], hypertrophy prostate w/o UR obst and other luts [without urinary retention and other other lower urinary tract symptom], urinary incontinence...."</p> <p>A nutritional care plan, dated 5/7/14, indicated "...serve 4 oz house supplement at lunch...."</p> <p>A progress note, dated 2/6/2014 at 13:55 (1:55 P.M.), indicated a "Weight concern ... Resident has had a continual weight loss. Resident intakes at this time are greater than 50% for most meals. Dietary will provide 4 oz house supplement for breakfast to aid in weight stabilization and continue with other current interventions. Will continue monitor for changes."</p>		<p>shakes) at breakfast and lunch. This deficient practice has the potential to affect all residents in the building. To insure that this finding does not recur, an in-service education program was given on 6/26/2014 to all dietary staff regarding the proper distribution of house supplements. The Dietary Manager updates the supplement list after the weekly weight and wound meeting and the new list is placed in the kitchen where all dietary staff can see it. The facility will use a QA tool "House Supplement Checklist" (Attachment D). The dietary manager or her designee will be responsible for completing the tool daily for 2 weeks then weekly for 4 weeks, then monthly thereafter. Any identified issues will be addressed immediately. Concerns/issues will be logged on the QA Summary Problem Log (Attachment B) and reviewed/revised monthly at the facility QA meeting to ensure ongoing compliance. An additional in-service education program was given on 6/28/2014, 6/29/2014, 6/30/2014 and 7/02/2014 to all staff who are responsible for charting meals and supplements in the dining rooms. A sticker was also placed on the menus of all residents receiving dietary supplements so staff members who record meal intake will be alerted to this fact. The facility will use the QA tool</p>				

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	<p>Resident #53's lunch was observed on 6/5/14 at 11:45 A.M. The house supplement was not provided with his lunch meal.</p> <p>During an interview on 6/5/14 at 12:05 P.M., the CDM (Certified Dietary Manager) indicated that dietary aides are responsible for providing house supplements and that Resident #53 is to receive a house supplement at lunch.</p> <p>On 6/6/14 at 9:45 A.M., review of Resident #53 "Food and Fluid Intake" for: May 7, 2014 thru June 5, 2014 indicated missing documentation of house supplement intake for 5/7/14, 5/8/14, 5/9/14, 5/11/14, 5/12/14, 5/13/14, 5/15/14, 5/16/14, 5/17/14, 5/21/14, 5/22/14, 5/23/14, 5/25/14, 5/27/14, 5/28/14, 5/29/14, 5/30/14, 6/1/14, 6/2/14, and 6/5/14.</p> <p>During an interview on 6/9/14 at 10:55 A.M., the CDM indicated "CNA's and activity personnel are to document resident intakes after every meal. No blanks, including the house supplement, should be on the FAR (Food and Fluid Acceptance Record)...."</p> <p>On 6/6/14 at 3:00 P.M., the DON (Director of Nursing) provided "Weight Management Program" policy, dated</p>		<p>"House Supplement Acceptance Record" (Attachment E), will be used daily for 2 weeks, then weekly for 4 weeks, then monthly thereafter by the dietary manager or her designee. Any identified issues will be addressed immediately. Concerns/issues will be logged on the QA Summary Proglem Log (Attachment B) and reviewed/revised monthly at the QA meeting to ensure ongoing compliance. Date of compliance 7/10/2014.</p>	

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F000325 SS=D	<p>7/07, and indicated it was the current policy used by the facility. The policy indicated "...2. Resident intakes will be documented on the Food & Fluid Acceptance Record.... "</p> <p>3.1-35(g)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to implement dietary recommendations for 1 of 3 sampled residents who met the criteria for weight loss since admission. (Resident #53)</p>	F000325	It is the policy of Miller's Merry Manor Walkerton to ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and the	07/10/2014

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	<p>Findings include:</p> <p>On 6/5/14 at 9:35 A.M., a review of the clinical record for Resident #53 was conducted. Resident 53's diagnoses included, but not were limited to, "...depressive disorder not elsewhere classified, peripheral vascular disease, paralysis agitans, atrial fibrillation, diab w/o comp type II/ uns not stated unctrl [diabetes without complication type II unspecified not stated as uncontrolled], hypertrophy prostate w/o UR obst and other luts [without urinary retention and other other lower urinary tract symptom], urinary incontinence...."</p> <p>Resident #53 weights indicated that his weight on 6/19/13 was 167.3 pounds and on 5/6/14 was down to 151.5 pounds, indicating a weight loss of 9.4%.</p> <p>A Dietary-RD (Registered Dietician) note, dated 10/15/13 at 9:53 A.M., indicated "...Reviewed chart due to gradual wt loss. ...BMI < [less than] 22...."</p> <p>A Dietary-RD Assessment, dated 1/20/14 at 7:51 A.M., indicated "... Weight 153.2 pounds ...BMI<22... at risk for malnutrition...wt loss less than 10% over the past 180 days; however, insidious wt</p>		<p>resident receives a therapeutic diet when there is a nutritional problem. Resident #53 was added to the weekly weight list, his care plan was updated to reflect these changes. Resident #53 is receiving house supplements at breakfast and lunch. Resident #53 also receives 1/2 cup of super cereal, a tablespoon of peanut butter and whole milk at breakfast, and supper pudding and whole milk at lunch. This deficient practice has the potential to affect all residents in the building. To insure that this finding does not recur, the dietary manager will review the Monthly Weight Report and identify residents with unplanned/undesired weight loss. The dietary manager will bring a list of these residents to the Weekly Weight, Wound and Hydration Meeting. The Weight, Wound and Hydration team will then review the resident's health care plans, intakes from the Food Acceptance Record and interview the resident, family or staff for clues regarding weight loss and suggestions for new interventions. The team will further discuss reasons for weight loss and will make changes to nutritional interventions and the plan of care. The Dietary manager will use a QA audit tool "Nutritional Indicators Audt" (Attachment F) daily for 2 weeks, then weekly for 4 weeks, then monthly thereafter. An additional</p>				

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	<p>loss...."</p> <p>A dietary note, dated 1/20/14, indicated "...At risk of malnutrition...BMI<22... wt loss less than 10% over the past 180 days; however, insidious wt loss...."</p> <p>A "Mini Nutritional Assessment" completed, on 2/6/14, by the CDM (Certified Dietary Manager) indicated "... height of 71.0 inches, a weight of 152 pounds, resulting in a BMI [body mass index] of 21.4.... substantial or insidious weight loss in past year...weight loss was unplanned/unexpected. Conclusion and recommendations: none, continue with current plan of nutritional care."</p> <p>A progress note, dated 2/6/2014 at 3:55 P.M., indicated "Weight concern ... Resident has had a continual weight loss. Residents' intakes at this time are greater than 50% for most meals. Dietary will provide 4 oz house supplement for breakfast to aid in weight stabilization and continue with other current interventions. Will continue monitor for changes."</p> <p>Resident 53's lunch was observed on 6/5/14 at 11:45 A.M. The house supplement was not provided with his lunch meal.</p>		<p>in-service education program was given on 6/28, 6/29, 6/30 and 7/2/2014 to all staff who are responsible for charting meals and supplements in the dining room A sticker was also placed on the menus of all residents receiving dietary supplements so staff members that do the charting will be alerted to this fact. The facility will use the QA tool "House Supplement Accetance Record"(Attachment E) daily for 2 weeks, then weekly for 4 weeks then monthly thereafter by the dietary manager or her designee. Any identified issues will be addressed immediately. Concerns/issues will be logged on the QA Summary Problem Log (Attachment B) and reviewed/revised monthly at the QA meeting to ensure ongoing compliance. Date of compliance 7/10/2014.</p>		

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	<p>During an interview on 6/5/14 at 12:05 P.M., the CDM (Certified Dietary Manager) indicated that dietary aides are responsible for providing house supplements and that Resident #53 is to receive a house supplement at lunch.</p> <p>On 6/6/14 at 9:45 A.M., a Review of the Food and Fluid Intake for: May 7, 2014 thru June 5, 2014, indicated missing documentation of house supplement intake for 5/7/14, 5/8/14, 5/9/14, 5/11/14, 5/12/14, 5/13/14, 5/15/14, 5/16/14, 5/17/14, 5/21/14, 5/22/14, 5/23/14, 5/25/14, 5/27/14, 5/28/14, 5/29/14, 5/30/14, 6/1/14, 6/2/14, and 6/5/14.</p> <p>On 6/6/14 at 10:50 A.M., review of the Nutritional care plan, dated 5/7/14, indicated to serve 4 oz house supplement at lunch.</p> <p>During an interview on 6/9/14 at 10:55 A.M., the CDM indicated "CNA's and activity personnel are to document resident intakes after every meal...no blanks, including the house supplement, should be on the FAR (Food and Fluid Acceptance Record)...."</p> <p>During an interview on 6/9/14 at 11:10 A.M., the DON (Director of Nursing) indicated that residents with a weight loss are placed on a weight loss list and</p>			

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F000371 SS=E	<p>discussed weekly. Review of the weight loss list found that resident #53 had not been placed on the list.</p> <p>On 6/10/14 at 9:30 A.M., review of a weight note dated 6/10/14 07:55, " Resident had a 2.5# weight loss from last month... dietary will try 4 oz house supplement with breakfast to aid in weight stabilization....."</p> <p>On 6/10/14 at 12:10 P.M., review of Resident #53's weight summary indicated a weight done on 6/9/14 showed a further weight loss to 149 pounds.</p> <p>3.1-46(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure meals were being served under sanitary conditions in regards to handwashing and proper use of hairnets. This had the</p>	F000371	It is the policy of Miller's Merry Manor Walkerton that the facility procure food from sources approved or considered satisfactory by Federal, Stae or Local Authorities; and we store,	07/10/2014

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	<p>potential to affect 62 out of 72 residents that receive meals from 1 of 1 kitchen.</p> <p>Findings include:</p> <p>On 6/2/14 from 11:30 A.M. to 12:11 P.M., observation of the lunch meal was conducted in the main dining room. During this time the following were observed:</p> <p>At 11:37 A.M., employee #3 was observed washing hands for 13 seconds, then served a meal to a resident.</p> <p>At 11:38 A.M., employee #3 was observed walking out of kitchen with a resident meal in her hands her hair net was pushed back on head with bangs hanging out. She then was observed washing her hands for 9 seconds then continuing to serve resident meals.</p> <p>At 11:40 A.M., employee #5 was observed putting on apron, walking to table and moving residents drinking glasses closer to him with out washing hands.</p> <p>At 11:47 A.M., employee #5 was observed in kitchen with hair hanging out of sides of hair net.</p> <p>At 11:54 A.M., employee #5 was</p>		<p>prepare, distribute and serve food under sanitary conditions. This deficient practice has the potential to affect all residents in the building. To insure the deficient practice does not recur, an in-service education program was held for all employees on 6/26/2014, 6/30/2014, 7/02/2014 and 7/03/2014 regarding hand washing and proper use of hairnets, in addition all employees had to demonstrate proper hand washing validating time and technique. The facility will use QA Tool "Handwashing/Handrub" (Attachment G),"Infection Control Review" (Attachment H) and "Food Safety Sanitation Checklist" (Attachment I) to audit compliance. All tools will be completed daily for 2 weeks, weekly for 4 weeks, then monthly thereafter by the Infection Control Nurse (hand washing), and the dietary manager or designee or assigned supervisory staff (hairnets). Any identified issues will be addressed immediately. Concerns/issues will be logged on the QA Summary Problem Lob (Attachment B) and reviewed/revised monthly at the QA meeting to insure ongoing compliance. A sign has been posted on the door to the kitchen alerting staff to wear hair nets upon entering. Date of compliance 7/10/2014.</p>				

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	<p>observed talking on telephone.</p> <p>Employee #5 then walked into the kitchen, retrieved a tray of jello from the walk in cooler, then served it to residents in main dining room without washing her hands.</p> <p>At 11:55 A.M., employee #3 was observed entering and exiting the kitchen with hairnet on but hair was hangout from the front and sides of the hairnet.</p> <p>On 6/2/14 at 11:55 A.M., during an interview with the CDM (Certified Dietary Manager), the CDM indicated the expectation was to have all their hair inside the hairnet when they were getting plates from the kitchen and were going into the kitchen.</p> <p>On 6/2/14 at 12:00 P.M., employee #5 was observed touching her sleeve, pulling down her shirt then went into kitchen, poured chocolate milk and served it to a resident.</p> <p>On 6/2/14 at 12:07 P.M., employee #5 was observed picking up resident water glass by top rim and then refilled it.</p> <p>On 6/5/14 at 11:29 A.M., employee #5 was observed leaning on table with both forearms while taking a residents lunch order, then walked into kitchen,</p>			

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	<p>retrieving a resident meal and serving it, without washing her hands.</p> <p>On 6/5/14 at 11:30 A.M., employee #5 was observed washing hands for 9 seconds then walking into kitchen with hair hanging out of left side of hairnet. She then served meal to resident.</p> <p>On 6/6/14 at 9:05 A.M., review of the policies " Personal Hygiene" dated 10-15-09 and " Hand Washing and Hand Asepsis" dated 7/27/12 indicated "....F. Food handlers shall wear hair restraints, hair coverings... to effectively keep hair from entering service equipment or food and reduce to the maximum extent feasible the likelihood of hand to hair contact... D... Rub vigorously for at least 20 seconds...."</p> <p>During an interview on 6/10/14 at 9:32 A.M., the DON indicated employees are expected to wash hands for 30 seconds after touching clothing or objects before serving a resident meal.</p> <p>3.1-21(i)(3)</p>			

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (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>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (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>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>			
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	<p>1. Based on observation, record review, and interview, the facility failed to follow policy and procedure for isolation precautions for 1 of 1 residents in isolation. (Resident #112)</p> <p>2. Based on observation, interview, and record review, the facility failed to ensure 3 of 3 nurses observed washed or sanitized hands properly prior to administration of medications and after direct resident contact. (LPN #4, RN #9, and RN #11).</p> <p>3. Based on observation and record review, the facility failed to ensure 1 of 1 resident observed was cleaned appropriately after being incontinent of urine. (Resident #84)</p> <p>Findings include:</p> <p>1. On 6-2-2014 at 1:45 P.M., a three drawer night stand was observed in the hall outside of Resident #112's room. Interview at this time with RN (Registered Nurse) #9 indicated Resident #112 is in isolation for C-Diff (Clostridium Difficile-an infection that requires contact isolation). No sign was observed at this time on the door indicating isolation precautions.</p> <p>On 6-3-2014 at 10:15 A.M. and 6-4-2014</p>	F000441	<p>It is the policy of Miller's Merry Manor Walkerton that hands remain clean during patient care and med pass and that contact isolation rooms are set up properly. On 6/5/2014 a stop sign was placed on the door. This deficient practice has the potential to affect all residents in the building. An in-service education program was held for all staff on 6/26/2014, 6/30/2014, 7/2/2014 and 7/3/2014 outlining the policies and procedures for isolation precautions, hand washing and hand asepsis, medication administration procedures, hand hygiene and peri care procedures. All employees had to demonstrate proper hand washing validating time and technique with the in-service director. The facility will use QA Tool "Hand washing/Hand Rub" (Attachment G), and "Infection Control Review" (Attachment H) daily for two weeks, weekly for 4 weeks and monthly thereafter. The in-service director will be responsible for completing these tools. Any identified issues will be addressed immediately and concerns/issues will be logged on the QA Summary Problem Log (Attachment B) and reviewed/revised monthly at the facility QA meeting to ensure ongoing compliance. Date of compliance 7/10/2014.</p>	07/10/2014			

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	<p>at 11:10 A.M., no sign was observed on the door indicating isolation precautions.</p> <p>On 6-5-2014 at 9:50 A.M., interview with LPN (Licensed Practical Nurse) #10 (the Infection Control Coordinator) indicated that there is usually a sign on the door directing visitors and staff to see the nurse before entering.</p> <p>On 6-5-2014 at 10:10 A.M., record review of "Transmission-based precautions room set-up" dated 5-30-2006, received from LPN #10 at this time, indicated "...C. Contact Transmission:...6. Post notification sign as per facility policy...."</p> <p>2. On 6-6-14 at 5:09 A.M., LPN (Licensed Practical Nurse) #4 was observed to give morning medications to the resident in Room #122 and then wash her hands for 10 seconds before preparing medications for the next resident.</p> <p>On 6-6-14 at 5:37 A.M., LPN #4 was observed to give morning medications to the resident in Room #107 and then wash her hands for 11 seconds before preparing medications for the next resident.</p> <p>On 6-6-14 at 8:54 A.M., RN (Registered</p>			

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	<p>Nurse) #11 was observed to use her bare hands to throw away a paper towel that a resident had used to wipe saliva off his face and then proceed to wash her hands for 8 seconds.</p> <p>On 6-6-14 at 8:56 A.M., RN #9 was observed to give morning medications to the resident in Room #224 and then wash her hands for 5 seconds.</p> <p>On 6-10-14 at 9:45 A.M., interview with the DON (Director of Nursing) indicated it was her expectation that staff wash hands for "...20 to 30 seconds...."</p> <p>On 6-10-14 at 10:00 A.M., review of the Hand Washing and Hand Asepsis policy, dated 7-27-12, received from the DON on 6-6-14 at 9:05 A.M., indicated "...Wet hands and wrists. Rub vigorously for at least 20 seconds...A. SPECIFIC TIMES HANDS MUST BE WASHED:...II. Before and after direct resident contact...."</p> <p>3. On 6-6-14 at 5:15 A.M., LPN #4 was observed to be giving morning medications to the roommate of Resident #84. While exiting the room, LPN #4 indicated to Resident #84 "Oh, you're wet... Let's get you changed..." LPN #4 was then observed to roll Resident #84 to his left side (towards the wall), roll up the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155574	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WALKERTON TR WALKERTON, IN 46574
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	<p>soiled bed linen pad underneath him before rolling him to the right side and removing them. LPN #4 placed the soiled linens in a linen bag and covered Resident #84 up with his sheet without washing his peri-area (groin area) and then exiting the room to continue her medication pass.</p> <p>On 6-6-14 at 9:05 A.M., interview with the DON indicated if a resident was incontinent of urine then "peri-care" should be completed. Review of the Peri Care Policy, dated 1-1-2009, received from the DON at this time, indicated "...Purpose: To cleanse the perineum for prevention of infection, irritation and to contribute to the residents positive self-image...Procedure:...F. Remove disposable brief or pad. G. Wipe off any excess feces with toilet paper or clean area of brief or pad. H. Roll the brief or pad in plastic bag. J. Remove soiled gloves and wash hands. K. Fill wash basin with warm water or wet clean cloth with warm water from sink. L. Apply clean gloves...N. Male: Wash from front to back, using soap product and a wet washcloth...Rinse and dry completely. Turn resident to side and cleanse anal areas thoroughly. Rinse and dry completely. O. Place soiled wash cloth in bag. P. Remove gloves and wash hands...."</p>			

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F009999 SS=D	<p>3.1-18(b)(2) 3.1-18(l)</p> <p>3.1-14 PERSONNEL</p> <p>(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (7) documentation of orientation to the facility and to the specific job skills</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure documentation of Charge Nurse Position Orientation was complete for 2 of 10 employee records reviewed. (LPN #6 and RN #7)</p> <p>Findings include:</p> <p>On 6/9/14 at 3:30 P.M., review of the employee records indicated the "Orientation - Charge Nurse Position" form was only partially filled out for LPN (Licensed Practical Nurse) #6 and RN (Registered Nurse) #7.</p>	F009999	<p>It is the policy of Miller's Merry Manor to maintain current and accurate personnel records on all employees. The two deficient records have been corrected. A complete employee record audit was conducted by the assistant office manager and any deficiencies found were corrected. New hires will only be oriented by the In-service director or the assistant office manager for consistency. All paperwork will be given a limited time for completion. A QA Audit tool "Employee Records Checklist" (Attachment J) will be used monthly by the assistant office manager on a random 10 employees to insure the files are accurate, compliant and current. Any identified issues will be addressed immediately. Concerns/issues will be logged on the QA Summary Problem Log (Attachment B) and reviewed/revised monthly at the facility QA meeting to insure ongoing compliance. Date of compliance 7/10/2014.</p>	07/10/2014

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	<p>In the file for LPN #6, 123 of 277 orientation topics were missing completion signatures indicating they were done.</p> <p>In the file for RN #7, 63 of 277 orientation topics were missing completion signatures indicating they were done.</p> <p>On 6/10/14 at 9:50 A.M., interview with the DON (Director of Nursing) indicated it was her expectation the orientation forms be completely filled out before they are placed in the employee file.</p> <p>On 6/10/14 at 10:15 A.M., review of the Orientation policy, dated 10/4/10, and received from the DON at this time, indicated "...A. All employees must complete a general orientation before they can begin work in the department to which they are assignment...."</p> <p>3.1-14(q)(7)</p>			