

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 28, 29, 30, 31, and April 1, 2015.</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Census bed type: SNF: 15 SNF/NF: 68 Total: 83</p> <p>Census payor type: Medicare: 12 Medicaid: 59 Other: 12 Total: 83</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0164 SS=D Bldg. 00	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</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>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to ensure a resident's privacy was respected while being administered medications via her gastric tube (g-tube) (a medical device used to provide nutrition to patients who cannot obtain nutrition by mouth) for 1 of 1 residents reviewed for privacy. (Resident #133)</p> <p>Finding includes: During a medication administration</p>	F 0164	<p>F-Tag 164 Personal Privacy/Confidentiality of Records</p> <p>It is the policy of Miller's Merry Manor Hobart for the residents to have the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Resident #133: The LPN was educated immediately on respecting resident's right to privacy when providing care i.e. closing the door.</p>	05/01/2015

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F 0241	<p>observation on 3/31/15 at 5:16 a.m., LPN #3 was observed entering Resident #133's room. She began assessing the resident by lowering her blanket and raising her gown to reveal her g-tube. She failed to close the door before she began assessing the resident and during the medication administration via the resident's g-tube.</p> <p>The record for Resident #133 was reviewed on 3/30/15 at 1:57 p.m. The resident's diagnoses included, but were not limited to, stroke and respiratory failure.</p> <p>Review of the Admission Record indicated the resident was nonverbal and received tube feedings.</p> <p>Interview with LPN #3 at the time of the medication administration indicated she should have provided the resident with privacy before she begun her assessment and during the resident's medication administration via her g-tube.</p> <p>3.1-3(p)(2)</p>		<p><i>All residents in the facility have the potential to be affected by this deficient practice.</i></p> <p>The facility will educate all staff on resident's right to privacy on or before 4/22/15. The importance of maintaining resident privacy during care procedures to enhance resident dignity will be reviewed.</p> <p>The administrator, social service designee, and nurse managers will be responsible to participate in routine walking rounds of the facility; 3 times a week for 2 weeks and 2 times a week thereafter; on varying shifts and at different times to monitor that resident's privacy is being maintained during resident care procedures.</p> <p>The corrective action will be monitored utilizing the QA tool "Observation Care Review" (Attachment A). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.</p>				

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SS=D Bldg. 00	<p>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, record review and interview, the facility failed to ensure each resident's dignity was maintained related to residents not being called by their name and not getting dressed during the day for 2 of 3 residents reviewed for dignity of the 5 residents who met the criteria for dignity. (Residents #6 and #60)</p> <p>Findings include:</p> <p>1. On 3/31/15 at 6:01 a.m., LPN #2 was observed administering medications to Resident #60. The LPN addressed the resident as "sweetie" rather than by her name.</p> <p>Interview with the LPN at the time, indicated the resident was not care planned for nicknames and she normally called the residents by their first name.</p> <p>Interview with LPN #4 on 4/1/15 at 10:35 a.m., indicated the resident should have been called by her name rather than "sweetie."</p>	F 0241	<p>F241 Dignity and Respect of Individuality: It is the policy of Miller's Merry Manor Hobart to promote care for the residents in an environment that maintains or enhances each resident's dignity and respect in full recognition of the his or her individuality. Resident # 60: The LPN was educated immediately on resident's rights to privacy and dignity in regards to calling resident's by their proper names and not a nickname.</p> <p>Resident #6: Resident's care plan was updated for resident to wear gowns per resident preference.</p> <p><i>All residents in the facility have the potential to be affected by this deficient practice.</i> The facility will educate all staff on addressing residents by their names and not nicknames and ensuring that residents are dressed in clothing of choice or preference on or before 4/22/15. Upon admission, quarterly, and with significant changes in status the social services director is responsible to review resident specific preferences for care. Each resident's plan of care includes individualized resident plan of care</p>	05/01/2015			

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	<p>2. On 3/28/15 at 10:30 a.m., 12:00 p.m., 1:40 p.m., and 3:20 p.m., Resident #6 was observed in bed wearing a hospital gown</p> <p>On 3/29/15 at 9:37 a.m., and 11:07 a.m., Resident #6 was observed in bed wearing a hospital gown.</p> <p>On 3/30/15 at 8:46 a.m., the resident was in bed wearing a hospital gown. At that time, the Hospice CNA was observed providing a.m. care. She indicated she always gets the resident dressed after she provides morning care. She indicated she comes to the facility three times a week.</p> <p>On 3/31/2015 at 9:30, 11:09 a.m., 1:46 p.m., and 2:43 p.m., the resident was observed in bed wearing a hospital gown.</p> <p>On 4/1/15 at 9:03 a.m., the resident was observed in bed wearing a hospital gown.</p> <p>Interview with CNA #3 on 4/1/15 at 9:10 a.m., indicated she had taken care of the resident before. She further indicated she was getting ready to provide morning care. CNA #3 indicated there was no reason why the resident could not be dressed in regular clothes rather than wearing a hospital gown.</p>		<p>indicating the resident preferences. The nurse aide assignment sheet will be updated as needed to reflect specific resident preferences and will serve as the communication tool for staff to be aware of care preferences.</p> <p>The administrator, social service designee, and nurse managers will be responsible to participate in routine walking rounds of the facility; 3 times a week for 2 weeks and 2 times a week thereafter; on varying shifts and at different times to monitor that residents are being addressed by their names and dressed per preference/choice. The corrective action will be monitored utilizing the QA tool "Observation Care Review" (Attachment A). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.</p>		

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	<p>Interview with LPN #1 on 4/1/15 at 9:15 a.m., indicated there was no reason why the resident could not be dressed in regular clothes rather than a hospital gown.</p> <p>The record for Resident #6 was reviewed on 3/30/15 at 12:47 p.m. The resident's diagnoses included, but were not limited to, chronic airway obstruction, anemia, renal failure, Alzheimer's disease, chronic kidney disease, and debility.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 3/12/15 indicated the resident's Brief Interview for Mental Status (BIMS) was a 3, indicating she was not alert and oriented. The resident had no behavior problems. The resident required total dependence with 1 person physical assist for dressing.</p> <p>The Significant Change MDS assessment dated 12/15/14 indicated the resident's BIMS score was an 8. She further indicated in her preferences it was very important to choose what clothes to wear.</p> <p>The current plan of care plan dated 3/25/15 indicated Preferences: resident expresses during the assessment process, that it was important to them to choose what clothes to wear.</p>			

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F 0246 SS=D Bldg. 00	<p>3.1-3(t)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record review and interview, the facility failed to ensure individual needs and preferences were provided related to ensuring a call light was in reach as well as ensuring the proper type of call light was in use for 2 of 2 residents reviewed for accommodation of needs. (Residents #60 and #73)</p> <p>Findings include:</p> <p>1. On 3/29/15 at 10:20 a.m., the call light for Resident #60 was observed on the floor behind the head of the resident's bed. The call light was out of the resident's reach.</p> <p>On 3/30/15 at 3:11 p.m., the resident was in her room in bed sleeping. The</p>	F 0246	<p>F 246 Reasonable Accommodation of Needs/Preferences: It is the policy of Miller's Merry Manor Hobart that residents have the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health of safety of the individual or other residents would be endangered. Resident #60: Resident experienced no negative outcomes related to the deficient practice. Resident was given call light and side rail added to resident's bed. Resident #73: Resident # 73 was provided with a touch pad call light to be placed under her chin. Staff was re-educated to call light is to be placed under resident #73 chin so that she will be able to use it. <i>All residents in the facility have the potential to be affected by this</i></p>	05/01/2015	

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	<p>resident's call light was on the floor next to her bed. The call light was out of the resident's reach.</p> <p>On 3/31/15 at 8:50 a.m., the resident was in her room in bed sleeping. The resident's call light was draped across the over bed table in her room. The over bed table was positioned away from the resident's bed next to the privacy curtain. The call light was not in reach at this time. At 9:54 a.m., the resident's call light remained out of reach.</p> <p>The record for Resident #60 was reviewed on 3/31/15 at 8:58 a.m. The resident's diagnosis included, but was not limited to, accidental fall.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 3/23/15, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. The quarterly MDS assessment also indicated the resident needed extensive assist with transfers.</p> <p>Interview with the resident on 3/29/15 at 10:15 a.m., indicated she could not reach her call light if it was behind the bed or on the floor.</p> <p>Interview with LPN #4 on 4/1/15 at</p>		<p><i>deficient practice.</i> The facility will educate all staff on ensuring all resident's call lights are within reach at all times and each resident has the appropriate call light that will meet their need on or before 4/22/15.</p> <p>The administrator, social service designee, and nurse managers will be responsible to participate in routine walking rounds of the facility; 3 times a week for 2 weeks and 2 times a week thereafter; on varying shifts and at different times to monitor that resident's call lights are within reach. The corrective action will be monitored utilizing the "Observation Care Review" (Attachment A). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.</p>				

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	<p>10:35 a.m., indicated the resident's call light should have been within reach.</p> <p>2. On 3/29/15 at 10:48 a.m., Resident #73 was observed in bed. There was a regular push button call light draped over the resident's chest. The resident's hands were both observed with two anti-contracture devices in them. Both of the resident's hands were in the shape of a fist and closed tightly.</p> <p>On 3/30/15 at 8:05 a.m., 12:57 p.m., and 1:50 p.m., the resident was observed in bed. There was a regular push button call light draped over the resident's chest. Both hands were contracted.</p> <p>Interview with CNA #1 and CNA #2 on 3/30/15 at 1:55 p.m., indicated the resident should have a touch pad call light cord so she can use her neck to press down on the pad to call for help. CNA #1 indicated the resident does shake her head yes and no when she wants something.</p> <p>On 3/30/15 at 3:00 p.m., the resident was observed in bed. She now had a touch pad for a call light, however, it was draped over the front of her and not under her neck area so she could use it.</p> <p>On 3/30/15 at 7:39 p.m., the resident was</p>			

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	<p>in bed. The touch pad call light was observed on her chest.</p> <p>On 3/30/15 at 8:44 p.m., the touch pad call light was hanging on the side rail.</p> <p>On 3/31/15 at 4:40 a.m., and 9:00 a.m., the touch pad call light was draped over her chest.</p> <p>The record for Resident #73 was reviewed on 3/30/15 at 8:19 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, diabetes mellitus, high blood pressure, epilepsy, gastrostomy status, dysphagia, and hemiplegia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 2/17/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 10, indicating she was alert and oriented. The resident had no mood or behavior problems. The resident was totally dependent on staff for all of activities of daily living. The resident had impairment on both sides to the upper and lower extremities.</p> <p>3.1-3(v)(1)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plans of care were followed as written related to ensuring fall interventions were in place for 1 of 4 residents reviewed for accidents of the 6 residents who met the criteria for accidents. The facility also failed to ensure bruises were monitored for 1 of 3 residents reviewed for bruising and the facility also failed to ensure oral care was completed for 1 of 3 residents reviewed for activities of daily living of the 4 residents who met the criteria for activities of daily living. The facility also failed to ensure insulin was given as ordered for 1 of 5 residents reviewed for unnecessary medications. (Residents #60, #73, and #82)</p> <p>Findings include:</p> <p>1. On 3/29/15 at 10:04 a.m., Resident #60 was observed with two large areas of reddish/purple bruising to her left forearm and her left upper arm. At 10:20 a.m., the call light for Resident #60 was observed on the floor behind the head of</p>	F 0282	<p>F-Tag 282 Services by Qualified Persons/Per Care Plan: It is the policy of Miller's Merry Manor, Hobart that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care related to bruises, side rails, oral care and insulin. Resident # 60: Assessment was completed and documented for this resident. Physician and Family were notified and orders received and noted; HCP updated. Side rail was added to resident's bed.</p> <p>Resident # 73: Oral care will be provided by qualified individual each shift and as needed to meet oral hygiene needs.</p> <p>Resident #82: An assessment was completed, no negative outcome noted due to the deficient practice. The Physician was notified of the med error new orders received; a med error report was completed and family was notified.</p> <p><i>All residents are at risk to be affected by the deficient practice.</i></p>	05/01/2015			

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	<p>the resident's bed. The call light was out of the resident's reach. The resident was in bed at this time. The resident's bed was also observed to have no side rails.</p> <p>On 3/30/15 at 3:11 p.m., the resident was in her room in bed sleeping. The resident's call light was on the floor next to her bed. The call light was out of the resident's reach and no side rails were observed on the resident's bed.</p> <p>On 3/31/15 at 8:50 a.m., the resident was in her room in bed sleeping. The resident's call light was draped across the over bed table in her room. The over bed table was positioned away from the resident's bed next to the privacy curtain. The call light was not in reach at this time. There were no side rails observed on the resident's bed. At 9:54 a.m., the resident's call light remained out of reach.</p> <p>The record for Resident #60 was reviewed on 3/31/15 at 8:58 a.m. The resident's diagnoses included, but was not limited to, accidental fall.</p> <p>The plan of care dated 11/12/14 and reviewed on 3/2015, indicated the problem of falls characterized by unsteady gait, poor trunk control, use of narcotics, use of antipsychotics, use of antihypertensive, use of assistive device,</p>		<p>Nurse managers will complete an audit of physician orders for insulin administration, review orders for side rail use and ensure in place as ordered, and will review head to toe skin assessments to ensure any areas of bruising have been identified and are monitored per policy by 5/1/15.</p> <p>All licensed nursing staff in-service will be completed on or before 4/22/15 to review the process for assessing, documenting and monitoring of bruises according to the facility policy. Licensed staff will also be in-serviced on following of physician's orders for insulin administration. Licensed and non-licensed staff will be in-serviced on ensuring side rails are in place according to the care plan and per physicians orders. At admission, annually, and with significant change in status a side rail assessment is completed to determine whether side rails are indicated. The physician is notified if the assessment indicates that side rails are necessary and an order for use is obtained. The bed is assessed to ensure that rails are in place as indicated by the physicians order and communication of use is provided to all direct care staff. Upon discovery of a new bruise the charge nurse is responsible to complete an initial assessment and report the findings to the physician and responsible party. The area of</p>	

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	<p>weakness and history of falls. The interventions included, but were not limited to, call light in reach and encourage to use handrails or assistive devices properly.</p> <p>The Physician's Order Summary (POS) for March 2015 indicated the resident was to have two half side rails up on bed to assist with mobility.</p> <p>The plan of care dated 3/16/15, indicated Bruise: Actual bruises face, right and left upper extremities. The interventions included, but were not limited to, monitor for increased size.</p> <p>The 3/2015 Medication Administration Record (MAR), indicated the resident's facial discoloration was to be monitored until resolved. There was no documentation on the MAR to indicate the bruising to the left arm was being monitored.</p> <p>Interview with LPN #4 on 4/1/15 at 10:35 a.m., indicated there should have been a sheet initiated for the areas on the arm and the resident should have had the side rails to her bed.</p> <p>2. The record for Resident #82 was reviewed on 3/30/15 at 2:08 p.m. The resident's diagnosis included, but was not</p>		<p>bruising will be identified and monitored on the facility TAR for monitoring x 7days.</p> <p>The DON or other designee will be responsible for routine audits of the MAR/TAR's and will review diabetic insulin orders to ensure administration occurs as ordered by completing the "Observation Care Review" (Attachment A) and "24 Hour Condition Report" (Attachment B) daily x1 week, then 3x weekly x 4 weeks, then weekly x4 weeks, and monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected upon discovery and documented on facility QA tracking log. QA tracking logs are reviewed monthly during the facility QA meeting.</p>		

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	<p>limited to, diabetes.</p> <p>A Physician's order dated 9/12/14, indicated the resident was to receive Novolog insulin 25 units three times a day. The insulin was to be held if the resident's blood sugar was less than 150.</p> <p>The March 2015 Medication Administration Record (MAR), indicated the following:</p> <p>3/8/15 7:00 a.m. blood sugar 138, the insulin was given to the resident. 3/18/15 7:00 a.m. blood sugar 150, the insulin was held.</p> <p>3/3/15 at noon blood sugar 109, insulin given. 3/19/15 at noon blood sugar 136, insulin given.</p> <p>3/6/15 at 5:00 p.m. blood sugar 173, insulin not given. 3/14/15 at 5:00 p.m. blood sugar 246, insulin not given. 3/15/15 at 5:00 p.m. blood sugar 265, insulin not given. 3/17/15 at 5:00 p.m. blood sugar 159, no documentation of insulin administration. 3/22/15 at 5:00 p.m. blood sugar 148, insulin given.</p> <p>The current plan of care indicated the</p>			

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	<p>resident was at risk for Hypo/hyperglycemia (low or high blood sugar) due to the diagnoses of Diabetes Mellitus. The interventions included, but were not limited to, give insulin as ordered.</p> <p>Interview with LPN #5 on 4/1/15 at 9:15 a.m., indicated the resident's insulin was not given as ordered according to the parameters.</p> <p>3. On 3/28/15 at 3:14 p.m., Resident #73 was observed in bed. At that time the resident's mouth was observed to be dry with dried mucous noted. There were also flakes of skin noted around her lips.</p> <p>On 3/29/15 at 10:05 a.m., the resident was in bed. The resident was able to communicate by shaking her head yes or no for the resident interview. She indicated by shaking her head no that staff did not brush her teeth or clean her mouth on a regular basis.</p> <p>On 3/30/15 at 9:23 a.m., until 10:40 a.m., CNA #1 and CNA #2 were observed to give the resident a complete bed bath due to it was the resident's shower day. Both CNAs washed the resident's entire body, however oral care was not provided. CNA #2 washed the resident's lips with a moist pink toothette. She then got two more toothettes and wiped the other side</p>			

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	<p>of the resident's lips. The resident did not resist. CNA #1 then applied chap stick to her lips and they continued with the rest of the bath. Neither CNA provided oral care or brushed the resident's teeth with the toothette before, during or after the bed bath.</p> <p>Interview with CNA #1 and CNA #2 3/30/15 at 1:55 p.m., indicated they did not provide oral care or brush the resident's teeth for the resident. CNA #2 indicated she only cleaned the resident's lips and CNA #1 applied the lip balm. CNA #2 indicated she should have placed the moist toothette in the resident's mouth and brushed her teeth</p> <p>The record for Resident #73 was reviewed on 3/30/15 at 8:19 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, diabetes mellitus, high blood pressure, epilepsy, gastrostomy status, dysphagia, and hemiplegia.</p> <p>The current 2/19/15 plan of care indicated the resident needed total assist with ADLs due to dementia and being totally dependent.</p> <p>The current 2/19/15 plan of care indicated potential for oral/dental problems related to own teeth. The</p>			

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F 0309 SS=D Bldg. 00	<p>Nursing approaches were to provide oral care twice a day and assist as needed.</p> <p>Interview with LPN #5 on 4/1/15 at 9:00 a.m., indicated the resident needed total assistance with all ADLS. She further indicated staff need to brush her teeth and provide oral care with morning care.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure areas of bruising were assessed and monitored for 2 of 3 residents reviewed for skin conditions (non-pressure related) of the 3 residents who met the criteria for skin conditions (non-pressure related). (Residents #60 and #134)</p> <p>Findings include:</p> <p>1. On 3/29/15 at 10:04 a.m., Resident #60 was observed with two large areas of</p>	F 0309	<p>F-Tag 309 Provide Care/Services for Highest Well Being: It is the policy of Miller's Merry Manor, Hobart to ensure that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident # 60: Assessment was completed and documented for this resident. Physician and Family were notified and orders received and noted; HCP updated. Side rails</p>	05/01/2015			

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	<p>reddish/purple bruising to her left forearm and her left upper arm.</p> <p>The record for Resident #60 was reviewed on 3/31/15 at 8:58 a.m. The resident's diagnoses included, but was not limited to, accidental fall.</p> <p>The readmission assessment dated 3/11/15 indicated the resident had discoloration to the left lower arm approximately 80% with reddish/blue/purple discoloration. Documentation on the assessment sheet indicated the following, "Add any skin alterations to the treatment record. All areas must be monitored at least daily until healed except bruises, only monitor for 7 days unless problems noted."</p> <p>The plan of care dated 3/16/15, indicated Bruise: Actual bruises face, right and left upper extremities. The interventions included, but were not limited to, monitor for increased size.</p> <p>The 3/2015 Medication Administration Record (MAR), indicated the resident's facial discoloration was to be monitored until resolved. There was no documentation on the MAR to indicate the bruising to the left arm was being monitored.</p>		<p>were added to resident's bed.</p> <p>Resident # 134: Assessment was completed and documented for this resident. Physician and Family were notified and orders received and noted; HCP updated. <i>All residents are at risk to be affected by the deficient practice.</i> Nurse managers will complete an audit of physician orders for insulin administration, review orders for side rail use and ensure in place as ordered, and will review head to toe skin assessments to ensure any areas of bruising have been identified and are monitored per policy by 4/23/15. All licensed nursing staff will be in-serviced by 4/22/15 to review the facility policy regarding assessing, documenting and monitoring of bruises according to the facilities policy. Licensed and non-licensed staff will be in-serviced on ensuring side rails are in place according to the care plan and per physicians orders. At admission, annually, and with significant change in status a side rail assessment is completed to determine whether side rails are indicated. The physician is notified if the assessment indicates that side rails are necessary and an order for use is obtained. The bed is assessed to ensure that rails are in place as indicated by the physicians order and communication of use is provided to all direct care staff. Upon discovery of a new bruise</p>		

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	<p>Interview with LPN #4 on 4/1/15 at 10:35 a.m., indicated there should have been a sheet initiated for the areas on the arm and the resident should have had the side rails to her bed.</p> <p>2. On 3/29/15 at 10:46 a.m., Resident #134 was observed with multiple areas of bruising to her left arm and wrist and right hand.</p> <p>The record for Resident #134 was reviewed on 3/30/15 at 3:02 p.m. The resident's diagnosis included, but was not limited to, anemia.</p> <p>The Nursing weekly assessment dated 3/28/15, indicated the resident had no new skin issues.</p> <p>There was no current non-pressure wound assessment sheet.</p> <p>The March 2015 Medication Administration Record (MAR) and Treatment Administration Record (TAR) were reviewed. There was no documentation related to the bruising to the left and right wrist areas.</p> <p>Interview with LPN #5 on 4/1/15 at 9:15 a.m., indicated the resident had areas of reddish/purple discoloration to the left forearm and wrist and right wrist. The</p>		<p>the charge nurse is responsible to complete an initial assessment and report the findings to the physician and responsible party. The area of bruising will be identified and monitored on the facility TAR for 7days. The nurse managers participate in routine audits of the MAR/TAR's and will review diabetic insulin orders to ensure administration per order. The DON or other designee will be responsible to complete the "Observation Care Review" (Attachment A) and "24 Hour Condition Report" (Attachment B) daily x1 week, then 3x weekly x 4 weeks, then weekly x4 weeks, and monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected upon discovery and documented on facility QA tracking log. QA tracking logs are reviewed monthly during the facility QA meeting.</p>		

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	<p>LPN was unaware of the areas, she indicated the resident does have a history of being combative and that could be where the bruises came from. She indicated that she would assess and measure the areas.</p> <p>The facility policy titled "Wound and Non-wound Assessment and Documentation" was reviewed on 3/31/15 at 9:43 a.m. The policy was provided by the Inservice Director and identified as current. The policy indicated the following: All non-wound skin alterations will be managed by the licensed staff nurses. Initial assessment and documentation will be completed on the "Nursing-New skin alteration assessment" or if new on admit on the "Nursing-admission/return assessment" or if due to an occurrence on the "nursing occurrence initial assessment" or on the "nursing daily assessment" located in the EMR (Electronic Medical Record). The non-wound area will be placed on the TAR with instructions to monitor as least daily until it is healed. Bruises will be monitored at least daily for seven days for complications such as pain that may indicate need for further assessment.</p> <p>3.1-37(a)</p>			

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F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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, record review, and interview, the facility failed to ensure a totally dependent resident received personal hygiene care related oral care and brushing teeth for 1 of 3 residents reviewed for Activities of Daily Living (ADLS) of the 4 residents who met the criteria for ADLS. (Resident #73)</p> <p>Finding includes:</p> <p>On 3/28/15 at 3:14 p.m., Resident #73 was observed in bed. At that time the resident's mouth was observed to be dry with dried mucous noted. There was also flakes of skin noted around her lips.</p> <p>On 3/29/15 at 10:05 a.m., the resident was in bed. The resident was able to communicate by shaking her head yes or no for the resident interview. She indicated by shaking her head no that staff did not brush her teeth or clean her mouth on a regular basis.</p>	F 0312	<p>F-Tag 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS: It is the policy of Miller's Merry Manor, Hobart to ensure that a resident who is unable to carry our activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident # 73: Oral care will be provided by qualified individual per plan of care and as needed to meet oral hygiene needs. All residents are at risk to be affected by the deficient practice. HCP's related to oral care and ADL care will be reviewed by 4/23/15 by nurse managers. All nursing staff will be in-serviced by 4/22/15 regarding delivery of care for dependent residents with emphasis on grooming, and personal/oral hygiene needs. The nursing assignment sheets will serve as a communication tool to identify care needs of residents, resident preferences, and interventions to meet the individual's plan of care. Charge</p>	05/01/2015

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	<p>On 3/30/15 at 9:23 a.m., until 10:40 a.m., CNA #1 and CNA #2 were observed to give the resident a complete bed bath due to it was the resident's shower day. Both CNAs washed the resident's entire body, however oral care was not provided. CNA #2 washed the resident's lips with a wet pink toothette. She then got two more toothettes and wiped the other side of the resident's lips. The resident did not resist. CNA #1 then applied chap stick to her lips and they continued with the rest of the bath. Neither CNA provided oral care or brushed the resident's teeth with the toothette before, during or after the bed bath.</p> <p>Interview with CNA #1 and CNA #2 on 3/30/15 at 1:55 p.m., indicated they did not provide oral care or brush the resident's teeth for the resident. CNA #2 indicated she only cleaned the resident's lips and CNA #1 applied the lip balm. CNA #2 indicated she should have placed the moist toothette in the resident's mouth and brushed her teeth</p> <p>The record for Resident #73 was reviewed on 3/30/15 at 8:19 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, diabetes mellitus, high blood pressure, epilepsy, gastrostomy status, dysphagia,</p>		nurses will be responsible to make daily walking rounds of unit during tour of duty to monitor that care is being delivered to the residents as indicated in plan of care. The corrective action will be monitored utilizing the QA tool "Observation Care Review" (Attachment A). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.		

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	<p>and hemiplegia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 2/17/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 10, indicating she was cognitively moderately impaired. The resident had no mood or behavior problems. The resident was totally dependent on staff for all of Activities of Daily Living (ADLS). The resident had impairment on both sides to the upper and lower extremities. The resident had no oral problems, broken dentures, or mouth or facial pain.</p> <p>The current 2/19/15 plan of care indicated the resident needed total assist with ADLs due to dementia and being totally dependent.</p> <p>The current 2/19/15 plan of care indicated potential for oral/dental problems related to own teeth. The Nursing approaches were to provide oral care twice a day and assist as needed.</p> <p>Interview with LPN #5 on 4/1/15 at 9:00 a.m., indicated the resident needed total assistance with all ADLS. She further indicated staff need to brush her teeth and provide oral care with morning care</p> <p>Review of the point of care tracker</p>						

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F 0323 SS=D Bldg. 00	<p>completed by the CNAs indicated am/pm includes oral care was signed out as being completed on 3/27 at 12:31 a.m., 9:22 a.m., and 10:57 p.m., and on 3/28 at 1:10 a.m., and 1:34 p.m. AM/PM care was not signed out as being completed on 3/29 and 3/30/15.</p> <p>3.1-38(a)(3)(C)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a resident who was at risk for falls had fall prevention measures in place related to side rails and having their call light in reach for 1 of 4 residents reviewed for accidents of the 6 residents who met the criteria for accidents. (Resident #60)</p> <p>Finding includes:</p> <p>On 3/29/15 at 10:20 a.m., the call light for Resident #60 was observed on the floor behind the head of the resident's bed. The call light was out of the</p>	F 0323	<p>F-Tag 323 Free of Accident Hazards/Supervision/Devices: It is the policy of Miller's Merry Manor, Hobart to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident # 60: Resident experienced no negative outcomes related to the deficient practice. Resident was given call light and side rail added to resident's bed. <i>All residents are at risk to be affected by the deficient practice.</i> The nurse managers will complete an audit of physicians order for side</p>	05/01/2015

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	<p>resident's reach. The resident was in bed at this time. The resident's bed was also observed to have no side rails.</p> <p>On 3/30/15 at 3:11 p.m., the resident was in her room in bed sleeping. The resident's call light was on the floor next to her bed. The call light was out of the resident's reach and no side rails were observed on the resident's bed.</p> <p>On 3/31/15 at 8:50 a.m., the resident was in her room in bed sleeping. The resident's call light was draped across the over bed table in her room. The over bed table was positioned away from the resident's bed next to the privacy curtain. The call light was not in reach at this time. There were no side rails observed on the resident's bed. At 9:54 a.m., the resident's call light remained out of reach.</p> <p>The record for Resident #60 was reviewed on 3/31/15 at 8:58 a.m. The resident's diagnoses included, but was not limited to, accidental fall.</p> <p>The Physician's Order Summary (POS) for March 2015 indicated the resident was to have two half side rails up on bed to assist with mobility.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 3/23/15, indicated the</p>		<p>rails and ensure in place/use as ordered by 4/23/15. The facility will educate all staff on ensuring all residents' call lights are within reach at all times and the care plan is being followed according to the appropriate safety interventions such as side rail use on or before 4/22/15. The charge nurse will be responsible to make routine walking rounds on unit to observe and ensure call lights are in place and side rail utilized as ordered by physician.</p> <p>The administrator, social service designee, and nurse managers will be responsible to participate in routine walking rounds of the facility; 3 times a week for 2 weeks and 2 times a week thereafter; on varying shifts and at different times to monitor that call lights are within reach and to monitor use of side rails as ordered by the physician.</p> <p>The corrective action will be monitored utilizing the QA tool "Observation Care Review" (Attachment A). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure</p>		

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	<p>resident was extensive assist for transfers.</p> <p>The plan of care dated 11/12/14 and reviewed on 3/2015, indicated the problem of Falls characterized by unsteady gait, poor trunk control, use of narcotics, use of antipsychotics, use of antihypertensive, use of assistive device, weakness and history of falls. The interventions included, but were not limited to, call light in reach and encourage to use handrails or assistive devices properly.</p> <p>The 3/8/15 Nursing Occurrence Initial Assessment indicated at 4:30 p.m., the resident was observed on the floor face down. The resident was sent to the Emergency room for evaluation and returned to the facility on 3/11/15.</p> <p>The 3/11/15 Fall risk assessment: indicated the resident had a history of falls in the past 30 days and required staff physical support for transfers. Side rail use was coded as "no".</p> <p>Interview with the resident on 3/29/15 at 10:10 a.m., indicated that she wished she had some type of side rail or grab bar to her bed to help her turn in bed.</p> <p>Interview with LPN #4 on 4/1/15 at 10:35 a.m., indicated the resident should</p>		ongoing compliance.		

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F 0329 SS=D Bldg. 00	<p>have had the side rails to her bed and the call light should have been within reach.</p> <p>3.1-45(a)(2)</p> <p>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 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 record review and interview, the facility failed to ensure insulin was administered as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident #82)</p>	F 0329	F-Tag 329: Unnecessary Medication It is the policy of Millers Merry Manor, Hobart that residents be free of unnecessary medications such as psychotropic medication and pain medications without proper indication for use.	05/01/2015

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	<p>Finding includes:</p> <p>The record for Resident #82 was reviewed on 3/30/15 at 2:08 p.m. The resident's diagnosis included, but was not limited to, diabetes.</p> <p>A Physician's order dated 9/12/14, indicated the resident was to receive Novolog insulin 25 units three times a day. The insulin was to be held if the resident's blood sugar was less than 150.</p> <p>The March 2015 Medication Administration Record (MAR), indicated the following:</p> <p>3/8/15 7:00 a.m. blood sugar 138, the insulin was given to the resident. 3/18/15 7:00 a.m. blood sugar 150, the insulin was held.</p> <p>3/3/15 at noon blood sugar 109, insulin given. 3/19/15 at noon blood sugar 136, insulin given.</p> <p>3/6/15 at 5:00 p.m. blood sugar 173, insulin not given. 3/14/15 at 5:00 p.m. blood sugar 246, insulin not given. 3/15/15 at 5:00 p.m. blood sugar 265, insulin not given.</p>		<p>Resident # 82: An assessment was completed; and no negative outcome noted due to the deficient practice. The Physician was notified of the med error, new orders received; a med error report was completed and family was notified. <i>All residents are at risk to be affected by the deficient practice.</i> The nurse managers will complete an audit of facility insulin orders by 4/23/15. Licensed staff will be in-serviced on or before 04/22/2015 to review the facility policy on the following of physician's orders and administering insulin according to the physician's order. The nurse managers participate in routine audits of the MAR/TAR's and will review diabetic insulin orders to ensure administration occurs as ordered. The DON or other designee will be responsible to complete the "24 Hour Condition Report" (Attachment B) daily x1 week, then 3x weekly x 4 weeks, then weekly x4 weeks, and monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected upon discovery and documented on facility QA tracking log. QA tracking logs are reviewed monthly during the facility QA meeting.</p>		

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F 0356 SS=B Bldg. 00	<p>3/17/15 at 5:00 p.m. blood sugar 159, no documentation of insulin administration. 3/22/15 at 5:00 p.m. blood sugar 148, insulin given.</p> <p>Interview with LPN #5 on 4/1/15 at 9:15 a.m., indicated the resident's insulin was not given as ordered according to the parameters.</p> <p>3.1-48(a)(3)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. 						

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	<p>o In a prominent place readily accessible to residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the daily staffing pattern was posted throughout the facility.</p> <p>Finding includes:</p> <p>On 3/28/15 at 8:15 a.m., the daily staffing sheet was not posted at the Main Entrance nor the West entrance. The staffing sheet was posted at the Main Entrance at approximately 1:00 p.m.</p> <p>On 3/29/15 at 8:37 a.m., 9:34 a.m., and 12:27 p.m., the staffing for 3/28/15 was posted at the Main Entrance. The staff sheet was not posted at the West entrance.</p> <p>On 3/31/15 at 8:40 a.m., the staffing for 3/30/15 was posted at the Main Entrance. The daily staffing was not posted at the West entrance.</p>	F 0356	<p>F-Tag 356: Posted Nurse Staffing Information It is the policy of Miller's Merry Manor, Hobart to post the nurse staffing information throughout the facility per requirements. No residents were affected by the deficient practice. All residents are at risk to be affected by the deficient practice. The facility policy for posting "Nurse Staffing Information" was reviewed by the DON and ADM on 3/31/15. Nurse managers will be in-serviced on policy by 4/22/15. Each morning the form will be posted to include the number of staff and the total hours of staff scheduled to provide direct care on each shift. The facility will post the form at a wheelchair height outside the front office and on the West Unit, which are accessible to both visitors and residents. The administrator and DON will monitor that staffing is posted per policy when making walking rounds of facility units. The night shift charge nurse or other designee will be responsible</p>	05/01/2015

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F 0441 SS=D Bldg. 00	<p>Interview with the Director of Nursing (DoN) on 3/31/15 at 9:07 a.m., indicated she was the person in charge of posting the staffing sheets. She indicated she had not completed the staffing this morning. She further indicated she was unaware the staffing sign had to be posted at the start of the shift. The DoN indicated no person was in charge to do the staffing sheets on the weekends.</p> <p>3.1-17(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <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</p>		to post the daily staffing form prior to the beginning the shift The corrective action will be monitored utilizing the QA tool "Observation Care Review" (Attachment A). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.		

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	<p>isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure bed pans, urinals, and wash basins were stored properly to prevent the spread of infection for 2 of 3 units. (The West and East units)</p> <p>Findings include:</p> <p>1. The following was observed during the Environmental tour on 4/1/15 at 9:15 a.m., on the West unit:</p> <p>A. There was a bedpan observed on top of the resident's closet in room 122. The</p>	F 0441	<p>F-Tag 441: Infection Control It is the policy of Miller's Merry Manor, Hobart to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Room #122, #127, #133, #105, #132 and #131: Urine collection containers and wash basins will be stored in individual plastic bags and placed in the bathrooms. <i>All residents are at risk to be affected by the deficient practice.</i> All nursing staff in-service will be held on or</p>	05/01/2015

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	<p>bed pan was uncovered. There were two residents who resided in the room.</p> <p>B. There was a wash basin stored on top of the resident's closet in room 127. There were two residents who resided in the room.</p> <p>2. The following was observed during the Environmental tour on 4/1/15 at 9:15 a.m., on the East unit:</p> <p>A. Room 133 there were wash two basins on the top of the closet shelf. Both basins were uncovered. There was one resident who resided in the room.</p> <p>B. Room 105 there were wash basins on the top of the closet. There was an urinal on the back of the toilet. Both the basins and the urinal were uncovered. There was one resident who resided in the room.</p> <p>C. Room 132 there was a bedpan on the floor in the bathroom. The bed pan was uncovered. There was one resident who resided in the room.</p> <p>D. Room 131 there was a bedpan on the floor in the bathroom. The bedpan was uncovered and it was turned upside down. There was one resident who resided in the room.</p>		<p>before 4/22/15 to review the facility policy/procedure on basic infection control practices for proper storage of urine collection containers and wash basins. The In-service Director or other designee will be responsible to complete the QA tool " Room Round Checklist" (Attachment D) daily x1 week, then 3x weekly for 3 weeks, then weekly for 4 weeks, then monthly thereafter to ensure ongoing compliance. . Any issues identified during observation will be immediately corrected and documented on facility QA tracking tool. The facility reviews all tracking logs during the monthly QA meeting to ensure ongoing compliance.</p>		

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F 0465 SS=E Bldg. 00	<p>Review of the current 5/30/2006 General Instructions for Cleaning Supplies/Equipment policy indicated "Bedpans/Urinals are disinfected after each use and returned to the resident unit as needed."</p> <p>Interview with the Housekeeping Supervisor on 4/1/15 at 9:50 a.m., indicated the basins, bedpans and urinals were stored uncovered.</p> <p>3.1-18(b)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the resident's environment was clean and good repair related to marred doors, marred walls, marred door frames, stained sinks, dusty ceiling vents, and cracked caulking for 3 of 3 units. (The West, Central, and East Units)</p> <p>Findings include:</p> <p>1. The following was observed during the Environmental tour on 4/1/15 at 9:15</p>	F 0465	<p>F-Tag 465: Safe/Functional/Sanitary/Comfortable Environment It is the policy of Miller's Merry Manor, Hobart to provide a safe and sanitary environment. All issues identified during the environmental tour were corrected on or before 4/22/15. <i>All residents in the facility have the potential to be affected by these findings.</i> An environmental walk through audit was completed to address any other areas that have the potential to affect other residents on or before 4/13/15. To ensure that this does not</p>	05/01/2015

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	<p>a.m., on the West unit:</p> <p>A. Room 123 the bathroom walls, door frame and bathroom door were gouged. There were two residents who resided in the room.</p> <p>B. Room 108 the bathroom door handle was loose and broken. There were two residents who resided in the room.</p> <p>C. Room 126 the bathroom door was marred and there was scuffed paint behind bed. One resident resided in room.</p> <p>D. Room 119 there was a build up of dirt and adhered dirt on the floor around and on the metal legs of the grab bars that were attached to the wall over the toilet in the bathroom. There were two residents who resided in the room.</p> <p>E. Room 116 the bathroom walls were marred and gouged. There were two residents who resided in the room.</p> <p>F. Room 113 the bathroom walls were spackled and in need of painting. The cove base was pulling away from the wall by the sink. The bathroom door frame and door were marred. There were two residents who resided in the room.</p>		<p>re-occur housekeeping supervisor and or designee will conduct daily rounds using the "Room Preparation Checklist" (Attachment E) three rooms, per unit daily for four weeks then two rooms, per unit weekly thereafter. Housekeeping and maintenance staff will be re-inserviced on cleaning procedures and identifying safety concerns in resident areas by 4/22/2015. Monitoring of the effectiveness of the system will be done weekly for four weeks and then monthly thereafter by the Administrator or designee using the General Observations Audit tool as part of the QA program.</p>		

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	<p>G. Room 123 There was a hole in wall in bathroom. The walls were marred. There was white plaster on the wall behind the toilet. There was two residents who resided in the room.</p> <p>H. Rooms 107 and Room 117 there was a build up of dirt and adhered dirt on the floor around and on the metal legs of the grab bars that were attached to the wall over the toilet in the bathroom. There were two residents who resided in each room.</p> <p>2. The following was observed during the Environmental tour on 4/1/15 at 9:15 a.m., on the Central unit:</p> <p>A. Room 143 The knob was loose on the drawer by the sink. There were two residents who resided in the room.</p> <p>B. Room 147 the cove base was detached from the base of the wall in the bathroom. The caulking around the toilet was discolored and cracked. There were two residents who resided in the room.</p> <p>C. Room 146 the base of the bathroom door was marred. The cove base in bathroom was loose and detached from the wall. There were rust stains on the countertop of the sink. There were two residents who resided in the room.</p>			

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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	<p>D. Room 139 there were yellow stains on the countertop of the sink. There were cracked floor tile edges underneath sink. There were two residents who resided in the room.</p> <p>E. Room 151 the cove base was loose behind room door. There was plaster missing in the wall. The caulk was peeling around edges of the sink. There were two residents who resided in the room.</p> <p>F. Room 153 the non skid strips were peeling in front of bed. There were two residents who resided in the room.</p> <p>G. Room 141 the plaster on the wall under the sink was peeling. There were two residents who resided in the room.</p> <p>3. The following was observed during the Environmental tour on 4/1/15 at 9:15 a.m., on the East unit:</p> <p>A. Rooms 133, 127, 105, 131, and 132 the bathroom ceiling vents were dusty and dirty. There was one resident who resided in each of those rooms.</p> <p>Interview with the Maintenance and Housekeeping Supervisors on 4/1/15 at 9:50 a.m., indicated all of the above were</p>			

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F 0498 SS=D Bldg. 00	<p>in need of cleaning and/or repair.</p> <p>3.1-19(f)</p> <p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 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. Based on observation, and interview, the facility failed to ensure a CNA only completed tasks and skills based on their competency related to removing a foam dressing from a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers of the 5 resident who met the criteria for pressure ulcers. (Resident #6)</p> <p>Finding includes:</p> <p>On 3/30/15 at 9:03 a.m., the Wound Nurse was preparing to do the treatment on Resident #6's pressure ulcer, due to it becoming loose during morning care provided by Hospice CNA #1. At that time the Wound Nurse washed her hands with soap and water and applied clean gloves. Hospice CNA #1 was holding the resident over onto to her side to assist</p>	F 0498	<p>F-Tag 498 Nurse Aide Demonstrate Competency/Care Needs It is the policy of Miller's Merry Manor Hobart to 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. Resident #6: The CNA was immediately re-educated on scope of practice for wound dressing removal/ scope of practice in long-term care setting. All wound dressings are applied and removed per licensed nurse and that non-licensed staff are not to apply/remove. Assessment completed on resident and physician notified of break in skin during the dressing removal; new orders received, HCP updated and family notified. <i>All residents in the facility have</i></p>	05/01/2015

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	<p>the Wound Nurse. Hospice CNA #1 stated to the Wound Nurse, "You are clean and I am dirty." Immediately at that time, the Hospice CNA pulled off the foam dressing on the resident's coccyx area. Under the dressing there was a pressure ulcer with a moderate amount of bloody drainage. There was also yellow slough (necrotic tissue) noted to the pressure ulcer. The surrounding skin was red. Continued observation, after the dressing was removed indicated there was a fresh open area where the adhesive part of the dressing was on the resident's right inner buttock area.</p> <p>Interview with the Wound Nurse at that time, indicated she had already changed the dressing earlier that morning, and the new open area noted on the right inner buttock was not there before. She indicated it must have happened when the dressing was removed.</p> <p>Interview with the Wound Nurse on 3/30/15 at 9:20 a.m., indicated she was unaware the Hospice CNA could not remove the dressing from the pressure ulcer. She indicated she knows the CNAs that work in the facility cannot remove the dressings.</p> <p>Interview with Hospice CNA #1 on 3/30/15 at 9:25 a.m., indicated she was</p>		<p><i>the potential to be affected by these findings.</i> The facility policy on pressure and non-pressure wound care will be provided to all hospice vendors to review with their staff prior to coming to facility by 4/22/15. All non-licensed staff will be in-serviced on the facility policy related to wound care and procedures on or before 04/22/2015. Licensed nursing staff will also be in-serviced regarding the scope of practice for non-licensed staff related to wound care. Non-licensed nursing staff will be advised to report any concerns related to residents skin, integrity of dressings etc... to the charge nurse and/or facility wound nurse. The wound nurse or other designee will be responsible to complete the QA tool titled "Wound/Non-pressure Wound Dressing Care" (Attachment F) daily x 1 week, then 3x weekly x 4 weeks, then weekly x4 weeks, and monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected upon discovery and documented on facility QA tracking log. QA tracking logs are reviewed monthly during the facility QA meeting.</p>		

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	<p>unaware she could not remove the dressings from pressure ulcers while she was in the nursing home. She indicated she had her home health certificate and she was able to do those things in the resident's homes.</p> <p>Interview with the Nurse Consultant on 4/1/15 at 10:00 a.m., indicated the Hospice CNA should not have removed the foam dressing from the resident's pressure ulcer.</p> <p>3.1-14(i)</p>				