

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 9, 10, 11, 12, and 13, 2015.</p> <p>Facility number: 000163 Provider Number: 155262 AIM number: 100291380</p> <p>Survey team: Laura Brashear, RN, TC Mary Weyls, RN Vickie Nearhoof, RN Geoff Harris, RN</p> <p>Census bed type: SNF: 10 SNF/NF: 64 Total: 74</p> <p>Census payor source: Medicare: 13 Medicaid: 41 Other: 20 Total: 74</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>March 2, 2015</p> <p>Indiana State Department of Health Division of Long Term Care 2 North Meridian Street Indianapolis, IN 46204-3006</p> <p>RE: Plan of Correction for Survey Event ID 4Q1Y11</p> <p>To Whom It May Concern:</p> <p>A Recertification and State Licensure Survey was conducted at our facility on February 13, 2015. Please find enclosed a Plan of Correction based on the CMS-2567 with Attachments A (pages 1-5), B, C, D (pages 1-8), E (pages 1-4), F (pages 1-2), G, H, I, J (pages 1-2) and K (pages 1-2). The Plan of Correction is respectfully submitted as remedies to the deficiencies that were found. We would like to request paper</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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F 164 SS=D Bldg. 00	<p>Quality review completed 02/17/2015 by Brenda Marshall, RN.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <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>compliance for the remedies submitted. In addition, a request has been submitted for an IDR on F 278. If you have any questions or require additional information, please contact me via phone at 812-268-6361.</p> <p>Sincerely,</p> <p>Debra Hale HFA Administrator</p>	

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	<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 transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and record review, the facility failed to ensure the resident's right for personal privacy during medication administration for 2 of 7 residents reviewed for medication administration (Resident's #100 and #75) and failed to ensure privacy of medical information during 1 random observation of staff discussing a resident's confidential information (Resident's #5).</p> <p>Findings include:</p> <p>1. On 2/12/15 at 12:15 p.m., LPN #1 administered insulin to Resident #100. With the resident sitting in a wheel chair and facing the hallway the nurse lifted the resident's shirt, exposing the resident's abdomen from below the chest area to well below the navel to administer the insulin. The door to the resident's room was open.</p>	F 164	<p>F 164 Personal Privacy/Confidentiality of Records The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F 164. I. It is the policy of Miller's Merry Manor to ensure that each resident has the right to personal privacy and confidentiality of his or her personal and clinical records. II. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) Staff education was conducted on 2/20/15 regarding resident privacy including during administration of medications such as eye drops and insulin. Education also included importance of ensuring confidentiality when communicating resident information. Staff were instructed to find private area to discuss resident information. (Attachment A, pages 1-3) 2) One on one education was conducted with</p>	03/02/2015	

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F 242 SS=D	<p>2. On 2/12/15 at 12:31 p.m., LPN #1 administered an eye drop to Resident #75. During the administration of the eye drop, the resident was facing the hallway and the door to the room was left open.</p> <p>3. On 2/12/15 at 9:50 a.m., a hospice CNA asked LPN #2 at the nurses' station if Resident #5's room had been changed and if the resident was still in isolation. The hospice CNA, asked the questions loudly as she was walking away from the east wing nurses' station. LPN #2 responded the resident was no longer in isolation and indicated the resident's room had been changed. During this conversation, five residents were sitting in a lounge across from the nurses' station.</p> <p>During review of the "Resident Rights Handbook" provided by the DON (Director of Nursing) on 2/12/14 at 2:49 p.m., documentation was noted, under the title of "Privacy and Confidentiality", "The resident has the right to personal privacy, and confidentiality of his or her personal and clinical records."</p> <p>3.1-3(u)(1)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO</p>		<p>LPN #1 and LPN #2 regarding failure to ensure personal privacy and both were instructed on how to follow proper policy and procedure to ensure resident personal privacy. 3) Hospice CNA staff was educated by Miller's Director of Nursing on 2/18/2015 regarding privacy and confidentiality of records. Hospice CNA's supervisor was contacted on 2/18/15 and 2/19/15 as well as Hospice Executive Director on 2/25/15 regarding resident personal privacy and confidentiality. III. The corrective action will be monitored to ensure the deficient practice will not recur by the Director of Nursing or designee to monitor personal privacy and confidentiality through the attached QA Tool (Attachment B). Personal privacy and confidentiality will be monitored through general observations on units and observations during medication administration. Monitoring will occur daily for one week, weekly for 4 weeks, then monthly thereafter for 6 months. Any issues will be corrected immediately, recorded on the facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented. IV. Corrective actions completed by 3/2/2015.</p>		

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Bldg. 00	<p>MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents' preferences for customary routines for number of weekly showers/baths, were honored for 3 of 3 residents reviewed who met the criteria for choices. (Residents #37, #75, and #100)</p> <p>Findings include:</p> <p>1. Resident #75 was interviewed on 2/9/15 at 12:06 p.m. The resident indicated she had not been asked how many times a week she preferred a shower or bath. The resident indicated she had been put on a schedule for two times a week.</p> <p>A CNA (certified nursing assistant) assignment sheet included documentation the resident was to be showered on Tuesdays and Sundays.</p> <p>Resident #75's clinical record was reviewed on 2/13/15. A significant change MDS (Minimum Data Set) assessment dated 12/31/14, coded the</p>	F 242	<p>F 242 Self Determination-Right to Make Choices The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F 242. I. It is the policy of Miller's Merry Manor to care for its residents in a manner and environment that the resident can make choices about aspects of his or her life in the facility that are significant to the resident. II. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) All current residents were interviewed regarding preferences for customary routines including the number of weekly showers/baths. Preferences voiced by the residents have been included in the residents care plan and CNA assignment sheet. 2) Staff education was conducted on 2/20/15 regarding honoring resident right to make choices. (Attachment A, pages 1-5.) III. The corrective action will be monitored to ensure the deficient practice will not recur by the Social Services Director and Unit</p>	03/02/2015			

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	<p>resident as required assistance with all activities of daily living (ADLs). The MDS section that addressed preferences for customary routines was noted of "How important is it to you to choose between a tub bath, shower, bed bath or sponge bath." It did not include the number of times the resident preferred to bathe a week.</p> <p>A care plan dated 2/11/15, included but was not limited to, an approach of "Needs extensive assistance with most ADLs allow to make own daily choices such as choosing what clothes to wear, one assist."2. Resident #100 was interviewed on 2/11/15 at 2:17 p.m. The resident indicated he had not been asked how many times he preferred to be bathed weekly and he was put on the shower schedule for two showers a week.</p> <p>On 2/11/15 at 2:43 p.m., the East Unit Manager indicated Resident #100 was on the shower schedule for two days a week, Wednesdays and Sundays.</p> <p>Resident #100's clinical record was reviewed on 2/11/15 at 2:29 p.m. An admission MDS (Minimum Data Set) assessment, dated 6/11/14, indicated the resident was cognitively alert and required extensive assistance of two for personal hygiene care.</p>		<p>Managers. The Social Services Director will conduct an assessment of preferences for customary routines including number of weekly showers/baths upon admission, quarterly and during resident care plan meetings. (Attachment C) Preferences will then be communicated in writing to the Unit Managers who will include preferences on the residents care plan and resident assignment sheet. In addition, compliance will be monitored by the Social Services Director by completing the QA Tool titled, QIS Resident Interview (Attachment D, pages 1-8) each month as assigned through the internal QA Program. Any issues will be corrected immediately, recorded on a facility QA Tracking Log, and reviewed in the facility QA meeting monthly with any new recommendations implemented. IV. Corrective actions completed by 3/2/2015.</p>		

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F 278 SS=D Bldg. 00	<p>3. During interview of Resident #37 on 2/9/15 at 12:18 p.m., the resident indicated she was scheduled for two showers a week.</p> <p>The most recent quarterly assessment, dated 12/01/14, indicated the resident had a moderate cognitive impairment and required extensive assistance of one person with personal hygiene needs.</p> <p>A nurses aide assignment sheet, received from the DON (Director of Nursing) on 2/12/15 at 12:03 p.m., indicated the resident received two showers a week.</p> <p>The Social Service Director (SSD) was interviewed on 2/13/15 at 10:56 a.m. The SSD indicated she did the MDS assessments related to preferences for customary routines. She indicated she did not ask residents how many times a week they preferred a shower or bath.</p> <p>3.1-3(u)(1)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p>				

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	<p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure the accuracy of the wound assessment used for the coding of the Admission Minimum Data Set for 1 of 1 resident reviewed with pressure ulcers (Resident #88).</p> <p>Finding includes:</p> <p>On 2/13/15 at 10:35 a.m., a review of Resident 88's Admission Minimum Data Set (MDS), dated 11/21/14, Section M (M0700) titled "Most Severe Tissue Type for Any Pressure Ulcer" indicated a code of 2-Granulation tissue.</p>	F 278	<p>Miller's Merry Manor of Sullivan is requesting a paper review IDR of tag F-278, Assessment accuracy/coordination/certification . Through this process we request that the tag be deleted completely. Please consider the deletion of this tag after reviewing additional information included here that was not provided to the surveyors at the time of the survey, as we thought the information we provided them had resolved the concern. The regulation states; the assessment must accurately reflect the resident's status. In reviewing the information cited in the findings, the assessment in questions, section M0700 of the MDS</p>	03/02/2015

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	<p>On 2/13/15 at 11:44 a.m., a review of the wound assessment report, dated 11/18/14, indicated the description of the wound as "...85% of wound bed noted to be red beefy granulation tissue and 15% of yellow fibrosis tissue."</p> <p>During an interview with the MDS Coordinator on 2/13/15 at 11:44 a.m., she indicated the coding for the MDS was based on the wound nurse's wound assessment. She indicated she used the wound assessment, dated 11/18/14, for the Admission MDS coding. She indicated she determined granulation tissue as the code on M700 because the assessment indicated 85% granulation and only 15 % fibrosis tissue.</p> <p>The MDS Coordinator indicated Resident #88 had two wounds She indicated she looked at the wound assessment for both wounds and chose the worst wound as the one she coded on the MDS assessment.</p> <p>On 2/13/15 at 2:31 p.m., the DON provided copies of a document titled " Medical Definition of Fibrous Tissue " and " slough-definition of slough by Medical dictionary. " He indicated the documents were used by the wound nurse to define the descriptions of wounds on the wound assessment. He indicated the</p>		<p>assessment on Resident #88 dated 11/21/14 was coded correctly as granulation tissue being the most severe tissue type present at the time of assessment. Please see attachment E pages 1-4, Wound: Pressure Ulcer assessment for resident #88 dated 11/18/14 that was completed by the facility Wound Nurse. Please give extra consideration to the answer to question #17 – Necrosis (eschar and/or slough), answered "NO". The Wound Nurse is confident that the tissue present at the time of the assessment was not that of slough. The description, yellow, by itself does not indicate slough. Please see attachment F pages 1-2, tissue type definitions by <i>Dorland's Medical Dictionary for Health Consumers. © 2007 by Saunders, an imprint of Elsevier, Inc.</i> Please see that there are several definitions that include the word "yellow" in the description. Please note specifically the definition: fibrous tissue the common connective tissue of the body, composed of yellow or white parallel fibers. By the RAI definition, Attachment G, Slough is tissue that is soft, stringy or mucinous in texture. The Wound Nurse, which has been assessing wounds for years and has had extensive training in wounds including completion of a Wound Management Certificate Program, Attachments H and I, is certain that the tissue present in the</p>		

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	<p>wound assessment was the document used by the MDS Coordinator to code the wound on the MDS.</p> <p>The Center for Medicare Services (CMS) Resident Assessment Instrument (RAI), Version 3.0 Manual, indicated, "...Code for the most severe type of tissue present in the pressure ulcer wound bed..." The RAI manual indicated the definition of slough tissue was, "Yellow or white tissue that is soft, stringy, or mucinous in texture...."</p> <p>3.1-31(d)</p>		<p>would was not slough and granulation was the most severe tissue present during the assessment period. In conclusion, the facility feels that the above information along with the attachments support the coding on the assessment to be accurate of the resident status at that time and request that tag F-278 be deleted. F 278 Assessment Accuracy/Coordination/Certified The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F 278. I. It is the policy of Miller's Merry Manor to ensure accuracy of wound assessments used for coding of the Minimum Data Set. II. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) One on one staff education with Director of Nursing and MDS Coordinator was completed by corporate MDS consultant on 2/24/2015. III. The corrective action will be monitored to ensure the deficient practice will not recur by the Director of Nursing and/or MDS Coordinator. The Director of Nursing or MDS Coordinator will monitor MDS coding on wounds on all MDS's that include wounds weekly for the next 6 months. (Attachment J, pages 1-2). Any issues will be corrected immediately, recorded on the</p>		

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F 282 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, interview, and record review, the facility failed to ensure physician's orders were followed for 1 of 1 resident reviewed with an order to wear compression stockings (Resident #100).</p> <p>Finding includes:</p> <p>On 2/10/15 at 2:15 p.m., Resident #100 was observed in his room, sitting in his wheelchair, wearing non-skid socks. The resident was not wearing compression stockings.</p> <p>On 2/11/15 at 10:26 a.m., Resident #100 was observed in his in room seated in a recliner, with legs down, wearing non-skid socks. The resident was again observed at 2:15 p.m. seated in a wheelchair with feet on floor wearing non-skid socks. The resident was not wearing compression stockings.</p>	F 282	<p>facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented.</p> <p>IV. Corrective actions completed by 3/2/2015.</p> <p>F 282 Services by Qualified Persons/Per Care Plan</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F 282.</p> <p>I. It is the policy of Miller's Merry Manor to ensure 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>II. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) Staff education was conducted on 2/20/15 to ensure physician orders are followed regarding compression stockings. (Attachment A, pages 1-2 and page</p>	03/02/2015

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	<p>On 2/12/15 at 9:47 a.m., Resident #100 was observed ambulating with a walker in the East Hall accompanied by CNA (Certified Nursing Assistant) #2 wearing non-skid socks. The resident was not wearing compression stockings.</p> <p>On 2/12/15 at 2:53 p.m., Resident #100 was observed wearing non-skid socks. The resident was not wearing compression stockings. He indicated that he was unable to put the support hose on by himself.</p> <p>On 2/12/15 at 2:55 p.m., RN #3 indicated the Treatment Administration Record(TAR) sheet showed that the night shift nurse, RN #4 ,had initialed the assignment sheet, which indicated support hose had been placed on Resident #100 that morning.</p> <p>On 2/12/15 at 2:58 p.m., The East Unit Manager indicated Resident #100 should have support hose put on in the morning and taken off in the evening. "Nursing is supposed to initial on the resident's TAR sheet when staff place support hose on the resident. If Resident #100 refused the support hose, the nurse should have circled her initials on the TAR. RN #4, the night shift nurse, had initialed the TAR that documented support hose were placed on Resident #100 that morning.</p>		<p>5)</p> <p>III. The corrective action will be monitored to ensure the deficient practice will not recur by the Director of Nursing or designee to monitor whether physician orders are followed for placement of compression stockings on resident #100 and any other resident with physician orders for compression stockings. The attached QA Tool will be utilized to monitor compliance (Attachment K, pages 1-2). Monitoring will occur daily for two weeks, weekly for 4 weeks, then monthly thereafter for 6 months. Any issues will be corrected immediately, recorded on the facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented.</p> <p>IV. Corrective actions completed by 3/2/2015.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2015
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	<p>The Unit Manager also indicated Resident #100 was wearing non-skid socks and should have had support hose on too.</p> <p>On 2/13/15 at 2:55 p.m., the Director of Nursing (DON) indicated Resident #100 often refused to wear support hose. The DON indicated the staff were to circle their initials on the (TAR) treatment sheet, if the resident refused care. The DON indicated there was not a refusal of care plan and the physician had not been notified of any refusal of care.</p> <p>Resident #100's clinical record was reviewed on 2/11/15 at 2:29 p.m. Diagnosis included but were not limited to, fluid overload, abnormality of gait, diabetes, arthritis, and gout.</p> <p>An admission Minimum Data Set (MDS) assessment dated 6/11/14, indicated the resident was cognitively alert and required extensive assist of two for personal hygiene care.</p> <p>A physician order dated 9/5/14 was noted of "...support hose on in the am (sic) and off in the pm (sic)..."</p> <p>A care plan, dated 9/5/14, for Resident #100 included but was not limited to, "Focus- Edema: to lower extremities.</p>			

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	<p>Risk: Dx [diagnosis] Fluid Retention. Goal- Will have no complications related to edema. Interventions: Support hose on the AM as ordered..."</p> <p>A policy, titled, "Manual: Nursing Policy & Procedure Manual," dated 02/24/2014, provided by the DON on 2/13/15 at 3:00 p.m., indicated, "...Show evidence that treatment or services provided are to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being...."</p> <p>3.1-31(d)</p>			