

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  02/19/2016
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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. This visit included the Investigation of Complaints IN00188677 and IN00192516.</p> <p>Complaint IN00188677- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00192516- Substantiated. Federal/State deficiencies related to the allegations are cited at F250.</p> <p>Survey dates: February 15, 16, 17, 18, and 19, 2016.</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Census bed type: SNF: 15 SNF/NF: 67 Total: 82</p> <p>Census payor type: Medicare: 13 Medicaid: 58 Other: 11 Total: 82</p>	F 0000		
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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 0241 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, on February 28, 2016.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. Based on observation, record review and interview, the facility failed to ensure a resident's foley catheter drainage bag was covered for 1 of 4 residents reviewed for urinary catheters of the 20 residents who met the criteria for urinary catheter use. (Resident #128)</p> <p>Finding includes:  On 2/15/16 at 9:30 a.m., Resident #128 was observed in her room in bed. The resident's foley catheter drainage bag was not covered at this time. The drainage bag which contained urine, was visible from the hallway.</p>	F 0241	<p><b>F241 Dignity and Respect of Individuality:</b> 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 # 128: Resident's foley bag was placed in cover. <i>All residents with a catheter in the facility have potential to be affected by this deficient practice.</i> The nurse managers checked all other residents with catheters to ensure that the foley bag was covered and urine was not visible by 3/17/16. The facility will educate all staff on ensuring all</p>	03/17/2016			

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	<p>On 2/16/16 at 3:30 p.m., the resident was observed in her room in bed. The resident's foley catheter drainage bag was not covered and urine was visible in the drainage bag from the hallway.</p> <p>On 2/17/16 at 8:10 a.m. and 9:05 a.m., the resident was observed in her room in bed. The resident's foley catheter drainage bag was not covered and urine was visible in the drainage bag from the hallway.</p> <p>The record for Resident #128 was reviewed on 2/17/16 at 9:15 a.m. A Physician's order dated 12/23/15, indicated to ensure the foley catheter bag was below the waist, covered, and the tubing was not touching the floor.</p> <p>Interview with the Director of Nursing on 2/18/16 at 10:00 a.m., indicated the resident's foley catheter bag should have been covered.</p> <p>The facility policy titled "Foley Catheter Care and Maintenance" was reviewed on 2/19/16 at 12:27 p.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated the following: Place drainage bag in a catheter cover bag underneath wheelchair or on side of bed.</p>		<p>foley bags are covered and urine is not visible on or before 3/17/16. Non-nursing personnel will be instructed to notify the charge nurse upon any observation of an uncovered urinary drainage bag. Nursing staff will be educated on importance of ensuring urinary drainage bag is maintained to promote resident dignity. 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) weeks, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on the 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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F 0242 SS=D Bldg. 00	<p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO 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. Based on record review and interview, the facility failed to honor a resident's preference related to how many times a week to bathe for 1 of 3 residents reviewed for choices of the 3 residents who met the criteria for choices. (Resident #116)</p> <p>Finding includes:</p> <p>Interview with Resident #116 on 2/16/16 at 9:15 a.m., indicated he would like to take a shower every other day. He indicated currently he received two showers a week.</p> <p>The record for Resident #116 was reviewed on 2/18/16 at 9:22 a.m. The resident's diagnoses included but were</p>	F 0242	<p><b>F-Tag 242 Self-Determination – Right to Make Choices</b> It is the policy of Miller's Merry Manor, Hobart that a resident has the right to choose activities, schedules and health care consistent with his or her interests, assessments and plans of care. Resident #116: Resident would like to have showers three days a week. Care plan and CNA assignment sheet have been updated. <i>All residents in the facility have the potential to be affected by this deficient practice.</i> Social Services reviewed and updated resident specific preferences to include type of bathing and frequency. CNA assignment sheets reflect all preferences by 3/17/16. Upon admission, quarterly, and with significant changes in status the</p>	03/17/2016	

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	<p>not limited to, adult failure to thrive, mental disorder, mood disorder, and dementia without behaviors.</p> <p>The Admission 6/11/15 Minimum Data Set (MDS) assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was alert and oriented. The resident indicated on the preference section it was very important to choose between a tub bath or shower.</p> <p>The Quarterly MDS assessment dated 1/12/16 indicated the resident's BIMS score was still 15.</p> <p>The current plan of care updated 1/2016 indicated it was very important for the resident to choose between a shower or bed bath. The 6/8/15 Nursing approach was "Preference for bathing is shower. Frequency of shower 5 times a week."</p> <p>The CNA care card indicated there was no information regarding the resident wanting to take a shower every other day. The card indicated the resident's shower days were Tuesday and Friday evenings.</p> <p>The shower sheets for the month of 12/2015 were reviewed. The resident received a shower on 12/1, 12/4, 12/8, 12/11, 12/22, and 12/29/15. There was</p>		<p>social services director is responsible to review resident specific preferences for care. 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. All nursing staff will be in-serviced on or before 3/17/16 on the importance of utilizing the nurse aide assignment sheets and being responsible to deliver the care as planned. Charge nurses will be responsible to make routine walking rounds during tour of duty to monitor that resident preferences for care are being delivered as per resident's 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.</p>		

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F 0250 SS=D Bldg. 00	<p>no documentation the resident had refused to take any showers.</p> <p>The shower sheets for the month of 1/2016 were reviewed. The resident received a shower on 1/1, 1/5, 1/8, 1/12, 1/15, 1/19, 1/22, 1/26, and 1/29/16.</p> <p>The shower sheets for the month of 2/2016 were reviewed. The resident received a shower on 2/2, 2/5, 2/9, 2/12, and 2/16/16.</p> <p>Interview with the Social Service Director on 2/18/16 at 10:00 a.m., indicated there was documentation the resident had requested 5 showers a week.</p> <p>Interview with LPN #2 on 2/19/16 at 9:35 a.m., indicated she was unaware the resident wanted more than 2 showers a week. She indicated he normally gets a shower on the evening shift, but we have given showers to him on the day shift before.</p> <p>3.1-3(u)(1)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>						

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	<p>Based on record review and interview the facility failed to ensure medically related social services were provided for the residents to maintain the highest practicable physical and psycho-social well being related to the discharge of a resident to a potentially unsafe environment for 1 of 1 resident reviewed for discharge planning. (Resident #B)</p> <p>Finding includes:</p> <p>The closed record for Resident #B was reviewed on 2/17/16 at 10:00 a.m. The resident was admitted to the facility from the hospital on 1/14/16. Diagnoses included, but were not limited to, cerebral infarction, multiple pressure ulcers, functional quadriplegia, colostomy, chronic obstructive pulmonary disease, hypertension, severe protein-calorie malnutrition, and medical neglect of an elder by caregiver.</p> <p>The Physician's order dated 1/21/16 indicated, discharge home 1/26/16 with Home Health Care.</p> <p>The Nursing Progress Note dated 1/26/16 at 3:47 p.m., indicated the resident's son here to sign discharge papers, instructions given and verbally understood, awaiting transport for discharge home. Continued review indicated, at 4:20 p.m., transport</p>	F 0250	<p>The facility is requesting to IDR F-Tag 250 and to have the tag deleted, please see attached written IDR</p> <p>It is the policy of Miller's Merry Manor, Hobart to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Resident #B: Resident was discharged from the facility. <i>All residents discharged from the facility have the potential to be affected by this deficient practice.</i></p> <p>An audit of each residents chart will be completed by 3/17/16 to ensure each resident has a discharge plan of care. Discharge planning begins on day of admission and the facility initiates the facility "Home Discharge Planning and Teaching Tool" which includes social service assessment of resident needs for home discharge. The facility conducts an initial care plan meeting with the resident and responsible party within the first 7 days after admission to discuss plans for discharge and on an on-going schedule until discharge. Re-education on the facility discharge program and ensuring that each resident is discharged to safe environment will be completed by 3/17/16. The corrective action will be monitored utilizing the QA tool "Observation Care Review" (Attachment A). Tool will be</p>	03/17/2016			

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	<p>here to transfer the resident home. Notified son of them leaving at this time with his mother to his house. There was no evidence of documentation indicating Social Services providing any at home evaluations.</p> <p>The General Progress Note by the Administrator dated 1/26/16 indicated, spoke with Adult Protective Services (APS) and the Police Department, they both verified the resident was able to return home with her son, there was no restraining order. Resident was scheduled to be discharged on 1/26/16.</p> <p>The resident's Hospital Admission History and Exam note dated 1/4/16 indicated the resident arrived via EMS (emergency medical services) with complaint of altered mental status, failure to thrive, and multiple wounds. She was found in her bed at home covered in fecal matter from her colostomy that had not been changed or cared for in some time. She lives at home with her son who was her primary caregiver. She has no other family in the area.</p> <p>The ED (emergency department) Nursing Note dated 1/4/16 indicated, the resident arrived covered in fecal matter with large necrotic wounds to her left shoulder and hip. She also had small wounds to her</p>		<p>completed daily for 1week, then 3x weekly for (3) weeks, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on the 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>coccyx. She appeared tachypenic (abnormally rapid breathing) and cachectic (loss of weight). The resident reported she was not able to care for herself at home, when asked why she doesn't go to a nursing home, she indicated, "my son wouldn't have any place to live." Continued review indicated, when the resident's son arrived to the ED he appeared to smell of alcohol and was verbally confrontational. The son was escorted out by security.</p> <p>The ED Provider Note dated 1/4/16 indicated, the paramedics found the resident in a filthy room in a bed which appeared to have not had changed bedding for months. The resident was soiled with her own feces and urine. She had multiple skin ulcerated wounds and appeared cachectic. It appears the resident has not been moved or cared for well for some time now.</p> <p>The ED Physical Exam indicated the following:</p> <ul style="list-style-type: none"> <li>-Blood Pressure, 123/58</li> <li>-Heart Rate, 104</li> <li>-Temp, 98.8 degrees Fahrenheit</li> <li>-Weight, 114 pounds</li> <li>-Height, 5' 4"</li> </ul> <p>The resident's colostomy was caked with feces, the bag was full and overflowing.</p>			

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	<p>Her torso and arms were soiled with feces. There was a stage 4 necrotic pressure ulcer to the left thoracic back, a stage 4 infected pressure ulcers to the left lateral and posterior thigh, and a stage 2-3 sacral pressure ulcer.</p> <p>The ED final diagnoses included, stage 3 pressure ulcer of left hip, stage 4 pressure ulcer of back, dehydration, malnutrition, renal insufficiency, hyperkalemia (high potassium in the blood), and wound infection.</p> <p>The Registered Dietician (RD) assessment dated 1/5/16 indicated the resident's bed scale weight was 83 pounds, a BMI (body mass index) of 15, indicating the resident was severely underweight. The RD progress note indicated, the resident was noted to be cachectic and emaciated (abnormally thin or weak, especially because of illness or a lack of food) in appearance. Resident with visible muscle wasting. APS notified of the resident's condition. Resident bed bound and living with her son, she reported a very poor appetite for a long time.</p> <p>Interview with Social Service Director #1 on 2/17/16 at 9:19 a.m., indicated the resident was discharged home on 1/26/16 with Home Health Care which included</p>			

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	<p>Nursing and CNA services. The resident refused therapy while in the facility and did not want therapy services upon discharge. She further indicated the facility was aware of the resident's living arrangements. The facility does not provide well being home visits prior to discharge. If the resident had agreed to therapy services there would have been an in home evaluation by the therapy department. Continued interview indicated Home Health does an in home evaluation once the resident's were discharged home.</p> <p>Confidential interview on 2/17/16 at 2:27 p.m., indicated while in the home the residence was noted to not have any running water.</p> <p>Interview with the Administrator on 2/17/16 at 2:50 p.m., indicated upon admission the facility was aware of the resident's history related to APS being informed of her condition and the police being involved related to the resident's son's behavior in the ED. She also indicated it was not within the facilities practices to conduct well being home visits prior to discharge. She indicated she called APS to inform them the resident was going to be discharged on 1/26/16. Continued interview indicated the son was not of her concern and why</p>						

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F 0282 SS=D Bldg. 00	<p>was it the facilities responsibility to ensure the resident was given a well being home assessment prior to discharge if APS and the Police had done nothing prior to her admission to the facility.</p> <p>Interview with the Corporate Consultant and the Administrator on 2/18/16 at 9:12 a.m., indicated the facility reviewed the systems they had in place to see if they failed the resident and the Consultant indicated she did not feel as though they had. "We wouldn't do anything different."</p> <p>This Federal tag relates to Complaint IN00192516.</p> <p>3.1-34(a)(5)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and</p>	F 0282	<b>F-Tag 282 Services by Qualified Persons/Per</b>	03/17/2016			

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	<p>interview, the facility failed to ensure only qualified staff members performed certain duties related to a CNA turned an enteral feeding pump (a machine used to infuse nutrition into a feeding tube) on hold while it was infusing. (Resident #60)</p> <p>Finding includes:</p> <p>On 2/17/16 at 8:59 a.m., Resident #60 was observed in bed. The resident had a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the resident's stomach used for nutrition) infusing an enteral feeding at 35 cubic centimeters (cc) an hour. At that time, CNA #1 was in the room and preparing to provide a bed bath for the resident. The CNA turned the enteral feeding pump on hold and lowered the head of the bed. The CNA proceeded to provide the bed bath.</p> <p>Interview with CNA #1 at that time, indicated she always turns the PEG tube on hold before lowering the head of the bed.</p> <p>The record for Resident #60 was reviewed on 2/17/16 at 2:31 p.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus, hemiparesis, seizure disorder,</p>		<p><b>CarePlan:</b> It is the policy of Miller's Merry Manor, Hobart to provide and/or arrange for services that meet professional standards of quality. Resident # 60:Gastrostomy tube care will only be provided by licensed nursing staff. Nurse aides will not be permitted to place feeding pumps on hold, stop and start tube feeding pumps. C.N.A.#1 was immediately re-educated and instructed not to turn feeding pump on hold, stop, or to restart feeding pump. <i>All residents with a gastrostomy tube and receiving feeding via pump are at risk to be affected by the deficient practice.</i> Licensed nursing staff will be responsible to provide all gastrostomy care which includes placing the pump on hold, stop, and starting. All facility nursing staff will be educated on or before 03/17/16 the standards of practice and that only licensed nursing staff will operate a resident's tube feeding pump. The nurse managers will make random walking rounds on various shifts 5 days per week to monitor and ensure that aides do not turn pumps on hold, off, or start and that the charge nurses are requested by nurse aides for all gastrostomy 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,</p>				

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	<p>depression, hypothyroidism, heart disease, cerebrovascular disease, gastroesophageal reflux disease, dysphagia, and PEG tube.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 2/11/16 indicated, the resident had a Brief Interview for Mental Status (BIMS) score of 7 which indicated severe impairment. The resident needed total assist with one person physical assist for bathing.</p> <p>Physician's Order dated 10/13/15 and on the current 2/2016 Medication Administration Record (MAR) indicated enteral feeding of Glucerna 1.2 at 35 cc per hour continuously.</p> <p>The care plan dated 12/9/14 indicated the resident required a PEG tube to assist in maintaining or improving nutritional and or hydration status due to diagnosis of dysphagia paralysis. Tube feeding related to not meeting calorie or hydration needs due to history of gastric bypass surgery and cannot tolerate large amounts of tube feeding. Check residual positioning of tube prior to feeding resident. Follow orders and elevate head of bed at all times. Notify physician and registered dietician with significant changes to evaluate formula and calories as needed.</p>		<p>then monthly by the DON or other designee. Any concerns identified will be documented on the 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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F 0309 SS=D Bldg. 00	<p>Interview on 2/17/16 at 2:31 p.m., with the Nurse Consultant, indicated the facility did not have a policy because the CNA's are not suppose to turn off tube feedings. It is out of their scope of practice.</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. Based on observation, record review and interview, the facility failed to ensure proper positioning devices were in use for residents in wheelchairs and broda chairs for 2 of 3 residents reviewed for positioning of the 3 residents who met the criteria for positioning. (Residents #23 and #75)</p> <p>Findings include:</p>	F 0309	<p><b>F-Tag309 Provide Care/Services for Highest Well Being:</b> 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. <b>Resident # 23:</b> Resident was screened by</p>	03/17/2016	

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	<p>1. On 2/16/16 at 9:06 a.m., Resident #75 was observed leaning to the right side in her wheelchair. There was a square throw pillow positioned on the right side of the wheelchair which was offering no support. The throw pillow was tucked down on the right side below the arm rest.</p> <p>On 2/18/16 at 8:34 a.m., the resident was seated in her room in her wheelchair. There was a square throw pillow inserted in the right side of the wheelchair. The resident was leaning to the right side. At 10:21 a.m., 1:33 p.m., and 8:20 p.m., the resident was seated in her wheelchair in her room. The resident was leaning against the throw pillow on her right side.</p> <p>The record for Resident #75 was reviewed on 2/18/16 at 10:23 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's and neuromuscular dysfunction.</p> <p>A quarterly Therapy Screen dated 9/3/15, indicated the resident had no significant change from prior level of function as per Nursing. No skilled therapy at this time.</p> <p>This was the last quarterly therapy screen available for review.</p>		<p>therapy and given a lateral positioner. <b>Resident #75:</b> Resident's foot rest were raised. <i>All residents are at risk to be affected by the deficient practice.</i> Each resident is screened by the therapy department for functional status and proper positioning a minimum of each quarter, with significant change in status, and upon request prn. Recommendation for positioning support/devices made by the therapy department will be implemented, care-planned, and communicated on the nurse aide assignment sheets. MDS coordinator or other designee will complete an audit of most current screen to ensure recommendations are in place and on HCP by 3/17/16. All licensed nursing staff will be in-serviced by 3/17/16 to review the importance of ensuring that positioning devices are used/ and are in place for each resident as per plan of care. Specialty positioning devices will be communicated on nurse aide assignment sheets to ensure nurse aides are aware of care needs. The charge nurses will be responsible to make walking rounds on unit during tour of duty monitoring the positioning of residents and to ensure positioning equipment in place as care planned. The DON or other designee will be responsible to complete the "Observation Care Review" (Attachment A) daily x1</p>		

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	<p>Interview with COTA #1 on 2/19/16 at 9:30 a.m., indicated the resident's quarterly therapy screen for 12/2015 was missed. She indicated she would assess the resident for positioning devices for her wheelchair.</p> <p>2. On 2/16/16 at 10:24 a.m., and 2:48 p.m., Resident #23 was observed sitting in a high back wheelchair. At those times, the resident's feet were dangling. There was no foot rest observed on the chair.</p> <p>On 2/17/16 at 9:05 a.m., and 9:52 a.m., the resident was observed sitting in a high back wheelchair. At those times, the resident's feet were dangling. There was no foot rest observed on the chair.</p> <p>The record for Resident #23 was reviewed on 2/17/16 at 9:15 a.m. The resident's diagnoses included, but were not limited to, pressure ulcer of sacral area, major depressive disorder, anxiety disorder, hearing loss, blindness and low vision, paraplegia, and convulsions.</p> <p>The Significant Change Minimum Data Set (MDS) assessment dated 12/15/15 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5, which indicated he was not cognitively intact and was severely impaired for decision making. The</p>		<p>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>resident was totally dependent on staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident had range of motion limitations and impairment to bilateral lower extremities. The resident's primary source of locomotion was a wheelchair.</p> <p>A therapy screen dated 1/18/16 indicated the patient was able to propel self in wheelchair.</p> <p>Another therapy screen dated 2/3/16 screen indicated patient can propel self in wheelchair at will. No therapy was recommended each time.</p> <p>Interview with LPN #2 on 2/17/16 at 10:37 a.m., indicated she was unaware his feet were not elevated. She further indicated he used a wheelchair to get around and was able to self propel his own chair. LPN #2 entered the resident's room at 10:45 a.m. At that time, she was unaware if the resident's wheelchair had foot pedals or a foot rest. A maintenance employee reached under the chair and pushed a lever and the foot rest became available. LPN #2 indicated she was completely unaware the resident had a foot rest on his wheelchair because it was so far under the chair and not viewable from a standing position.</p>			

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F 0322 SS=D Bldg. 00	<p>3.1-37(a)</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure a resident received the correct amount of enteral feeding (a liquid nutritional substance) through a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into a resident's stomach that provided nutrition) for 1 of 1 residents reviewed for tube feeding. (Resident #100)</p> <p>Finding includes:  On 2/17/16 at 9:00 a.m. and 9:26 a.m.,</p>	F 0322	<p><b>F-Tag322: NG Treatment/Services – Restore Eating Skills</b> It is the policy of Miller's Merry Manor, Hobart to ensure a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services. Resident #100: An assessment was completed, no negative outcome noted due to the deficient practice. Nurse was re-educated on ensuring that tube feeding is started/maintained per physicians order. <i>All residents with a gastromy tube and receive feeding via pump are at risk to be</i></p>	03/17/2016	

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	<p>Resident #100 was observed in bed. At that those times, the resident's PEG tube feeding was turned off.</p> <p>On 2/17/16 at 9:45 a.m., LPN #2 was observed to turn the enteral feeding back on.</p> <p>On 2/18/16 at 8:10 a.m. and 8:21 a.m., the resident's PEG tube feeding was turned off.</p> <p>On 2/18/16 8:30 a.m., LPN #2 was observed to turn the PEG tube feeding back on.</p> <p>The record for Resident #100 was reviewed on 2/16/16 at 3:16 p.m. The resident's diagnoses included, but were not limited to, PEG tube, anoxic brain syndrome, tracheotomy, and mild intellectual disabilities.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 1/26/16 indicated the resident was severely impaired for decision making. The resident was totally dependent on staff for Activities of Daily Living. The resident had a PEG tube and received more than 51% of nutrition through the tube. The resident also had pressure ulcers.</p> <p>Physician Orders on the current 2/2016</p>		<p><i>affected by the deficient practice.</i></p> <p>Nurse managers completed an audit of all feeding tubes and scheduled feeding times by 3/17/16 to ensure compliance with starting and stopping per physician orders. Licensed nursing staff will be responsible to provide all gastrostomy care which includes placing the pump on hold, stop, and starting. Physician orders for starting/holding/stopping feeding tube will be followed as ordered. All facility nursing staff will be educated on or before 03/17/16 the standards of practice and that only licensed nursing staff will operate a resident's tube feeding pump. The nurse managers will make random walking rounds on various shifts 5 days a week to monitor and ensure that aides do not turn pumps on hold, off, or start and that the charge nurses are requested by nurse aides for all gastrostomy care.</p> <p>Observations to ensure tube feedings are delivered as ordered by the physician. 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 the quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be</p>		

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F 0441 SS=D Bldg. 00	<p>recap indicated Jevity 1.5 (an enteral feeding) 105 cubic centimeters (cc) per hour for 16 hours daily. The feeding is to be off at 4:00 a.m. and on at 8:00 a.m., and off at 7 p.m. and on at 11 p.m. The resident was to have nothing by mouth (NPO).</p> <p>Interview with the LPN #2 on 2/19/16 at 2:00 p.m., indicated she was in the dining room assisting residents with feeding at 8:00 a.m., when the tube feeding was to be turned back on.</p> <p>Interview with the Director of Nursing on 2/19/16 at 2:40 p.m., indicated the West Unit Nurse was to relieve the Central Nurse at 8:00 a.m., from the dining room, so LPN #2 could have returned to her unit timely and turned the tube feeding pump back on.</p> <p>3.1-44(a)(2)</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</p>		<p>reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.</p>				

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	<p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as 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</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure hand washing was completed after glove removal for 1 of 1 glucometers observed. (Resident #101)</p> <p>Finding includes:</p> <p>On 2/18/16 at 8:54 p.m., LPN #1 proceeded to enter Resident #101's room to perform a glucometer (a test to check</p>	F 0441	<b>F-Tag441: Infection Control</b> 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. Nurse was immediately inserviced on handwashing policy <i>All residents are at risk to be affected by the</i>	03/17/2016	

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	<p>blood sugar levels). The LPN applied gloves, cleansed the resident's finger with an alcohol wipe, and checked the resident's blood sugar. The LPN proceeded to walk out of the resident's room with her gloves on. The LPN removed her gloves at the medication cart and discarded the gloves. The LPN did not wash her hands nor use an alcohol based hand gel. The LPN then proceeded to prepare the resident's insulin injections. The LPN then re-entered the resident's room with the insulin syringes. The LPN applied gloves, administered the insulin, removed her gloves in the resident's room, disposed of the syringes in the sharps container on the medication cart, signed out the medications and then proceeded to use hand gel to clean her hands.</p> <p>Interview with the Administrator and Nursing Consultant on 2/19/16 at 9:30 a.m., indicated the LPN should have washed her hands when the gloves were removed and she should have removed the gloves prior to leaving the resident's room.</p> <p>The facility policy titled "Use of Medical Gloves (application and removal)" was reviewed on 2/19/16 at 9:49 a.m. The policy was provided by the Director of Nursing and identified as current. The</p>		<p><i>deficient practice.</i> All nursing staff in-service will be held on or before 3/17/16 to review the facility policy/procedure on handwashing and glove use. The In-service Director or other designee will complete a handwashing /gloving observation of all nurses who participate in medication/treatment administration by 3/17/16 to ensure knowledge and propertechnique. The In-service Director or other designee will be responsible to complete the QA tool "Observation Care Review " (Attachment A) 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>policy indicated the following: "Hands should be washed initially prior to putting on the gloves. Gloves should be removed and hands washed with soap and water immediately after glove removal. (Hand washing with soap and water is highly recommended when gloves are removed because of a tear or puncture and the HCW has had contact with blood or another body fluid, hand rub with alcohol gel may be used only if soap and water is not available upon removal of gloves.)"</p> <p>3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE 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 maintain a functional environment related to marred walls and doors, rusted faucets, cracked trim, discolored ceiling tile on 3 of 3 units throughout the facility (East Hall, Central</p>	F 0465	<p>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 3/7/16. <i>All residents in the facility have the potential to be affected by</i></p>	03/17/2016			

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	<p>Hall, and West Hall ).</p> <p>Findings include:</p> <p>During the Environment Tour on 2/19/16 at 11:50 a.m., with the Administrator, Senior Maintenance Employee, and Director of Supplemental Support the following was observed. (The East, West, and Central Hall)</p> <p>1. East Hall</p> <p>a. The heat vent on the bedroom wall was not fitting properly in Room 103. The wood trim along the ceiling next to the blinds was cracked. One resident resided in this room.</p> <p>b. The toilet bowl was discolored in Room 114. One resident resided in this room.</p> <p>c. The edge of the bathroom door was marred and chipped in Room 119. The paint was chipped and the wall behind the head of the bed was marred. One resident resided in this room.</p> <p>2. West Hall</p> <p>a. The inside bathroom door was marred in Room 106. Two residents shared this bathroom.</p>		<p><i>these findings.</i></p> <p>An environmental walk through audit was completed to address any other areas that have the potential to affect other residents on or before 3/17/16. To ensure that this does not re-occur housekeeping supervisor and or designee will conduct daily rounds using the "Room Preparation Checklist" (Attachment B) three rooms, per unit daily for four weeks then two rooms, per unit weekly thereafter. Maintenance staff will be re-inserviced on cleaning procedures and identifying safety concerns in resident areas by 3/7/2016. 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>b. The floor was marred and discolored by the foot of the resident's bed in Room 111. Two residents resided in this room.</p> <p>c. The non-skid strips were peeling off in the bathroom in Room 112. Two residents shared this bathroom.</p> <p>d. The non-skid strips were peeling off in the bathroom in Room 112. Two residents shared this bathroom.</p> <p>e. The inside bathroom door was marred in Room 117. Two residents shared this bathroom.</p> <p>f. The faucet in the bathroom was rusted, and the molding was cracked around the sink in Room 121. Two residents resided in this bathroom.</p> <p>3. Central Hall</p> <p>a. The bathroom door was marred and gouged, and a chunk of plastic was missing from the bedroom door in Room 139. Two residents shared this bathroom.</p> <p>b. The wall behind the residents bed was marred and gouged in Room 140-2. The bathroom door was also marred and gouged, and the ceiling tile in the</p>			

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	<p>bathroom was stained. Two residents resided in this room and shared the bathroom.</p> <p>c. The wall behind the bed was marred and gouged in Room 141-2. Two residents shared this room.</p> <p>d. The bedroom door was chipped and cracked. The bathroom ceiling tile was stained and the floor register on the wall was dirty and dusty in Room 142.</p> <p>e. The track above the bathroom door was dirty and discolored in Room 145. Two residents shared this bathroom.</p> <p>f. The tile in the bathroom was broken, and the toilet bolts were rusty. The ceiling tile in the bathroom was stained in Room 146. Two residents shared this bathroom.</p> <p>Interview at that time with the Administrator, Senior Maintenance Employee, and Director of Supplemental Support, indicated all of the above areas were in need of cleaning and/or repair.</p> <p>3.1-21 (i)(2) 3.1-21 (i)(3)</p>			

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F 0520 SS=D Bldg. 00	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review and interview, the facility failed to identify positioning as an area of concern through the Quality Assurance Protocol.</p> <p>Findings include:</p> <p>Interview with the In-service Director on 2/19/16 at 1:00 p.m., indicated the facility's Quality Assurance Committee meets every month and consists of</p>	F 0520	<p>It is the policy of Miller's Merry Manor, Hobart to maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p><b>Resident# 23:</b> Resident was screened by therapy and given a lateral positioner. <b>Resident #75:</b> Resident's foot rest were raised. <i>All residents are at risk to be</i></p>	03/17/2016			

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	<p>herself, the Administrator, the Director of Nursing, MDS Coordinator, Social Service, Dietary, Activities, Medical Records, as well as the Medical Director. The In-service Director indicated at the time, positioning such as turning, lifting, transferring had been discussed, addressed or identified in Quality Assurance.</p> <p>1. On 2/16/16 at 9:06 a.m., Resident #75 was observed leaning to the right side in her wheelchair. There was a square throw pillow positioned on the right side of the wheelchair which was offering no support. The throw pillow was tucked down on the right side below the arm rest.</p> <p>On 2/18/16 at 8:34 a.m., the resident was seated in her room in her wheelchair. There was a square throw pillow inserted in the right side of the wheelchair. The resident was leaning to the right side. At 10:21 a.m., 1:33 p.m., and 8:20 p.m., the resident was seated in her wheelchair in her room. The resident was leaning against the throw pillow on her right side.</p> <p>A quarterly Therapy Screen dated 9/3/15, indicated the resident had no significant change from prior level of function as per Nursing. No skilled therapy at this time.</p>		<p><i>affected by the deficient practice.</i></p> <p>All staff will be in-serviced by 3/17/16 on the facility process for identifying concerns and reporting to the QAA team/committee.</p> <p>Each resident is screened by the therapy department for functional status and proper positioning a minimum of eachquarter, with significant change in status, and upon request prn.</p> <p>Recommendation for positioning support/devices made by the therapy department will be implemented, care-planned, and communicated on the nurse aide assignment sheets. MDS coordinator or other designee will complete an audit of most current screen to ensure recommendations are in place and on HCP by 3/17/16. All licensed nursing staff will be in-serviced by 3/17/16 to review the importance of ensuring that positioning devices are used/ and are in place for each resident as per plan of care. Specialty positioning devices will be communicated on nurse aide assignment sheets to ensure nurse aides are aware of care needs. The charge nurses will be responsible to make walking rounds on unit during tour of duty monitoring the positioning of residents and to ensure positioning equipment in place as care planned. The DON or other designee will be responsible to complete the "Observation Care Review" (Attachment A) daily x1</p>		

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	<p>This was the last quarterly therapy screen available for review.</p> <p>Interview with COTA #1 on 2/19/16 at 9:30 a.m., indicated the resident's quarterly therapy screen for 12/2015 was missed. She indicated she would assess the resident for positioning devices for her wheelchair.</p> <p>2. On 2/16/16 at 10:24 a.m., and 2:48 p.m., Resident #23 was observed sitting in a high back wheelchair. At those times, the resident's feet were dangling. There was no foot rest observed on the chair.</p> <p>On 2/17/16 at 9:05 a.m., and 9:52 a.m., the resident was observed sitting in a high back wheelchair. At those times, the resident's feet were dangling. There was no foot rest observed on the chair.</p> <p>A therapy screen dated 1/18/16 indicated the patient was able to propel self in wheelchair.</p> <p>Another therapy screen dated 2/3/16 screen indicated patient can propel self in wheelchair at will. No therapy was recommended each time.</p> <p>Interview with LPN #2 on 2/17/16 at 10:37 a.m., indicated she was unaware</p>		<p>week, then 3xweekly 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. The Nurse Managers will be responsible to make random walking rounds on all shifts to monitor for any concerns with residents that have not been addressed and needs to be reported to the QAA committee on an ongoing basis. 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 and followed for the next year to ensure ongoing compliance.</p>		

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	<p>his feet were not elevated. She further indicated he used a wheelchair to get around and was able to self propel his own chair. LPN #2 entered the resident's room at 10:45 a.m. At that time, she was unaware if the resident's wheelchair had foot pedals or a foot rest. A maintenance employee reached under the chair and pushed a lever and the foot rest became available. LPN #2 indicated she was completely unaware the resident had a foot rest on his wheelchair because it was so far under the chair and not viewable from a standing position.</p> <p>Further interview with the In-service Director on 2/19/16 at 1:16 p.m., indicated the above positioning concerns should have been recognized by staff and monitored.</p> <p>3.1-52(b)(2)</p>			