

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  09/30/2011
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN47882
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 26, 27, 28, 29, and 30, 2011</p> <p>Facility number: 000163 Provider number: 155262 AIM number: 100291380</p> <p>Survey Team: Teresa Buske RN-TC Debra Skinner RN Mary Weyls RN Laura Brashear RN</p> <p>Census bed type: SNF: 9 SNF/NF: 76 Total: 85</p> <p>Census payor type: Medicare: 17 Medicaid: 53 Other: 15 Total: 85</p> <p>Stage 2 Sample: 36</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	Please see cover letter which was uploaded in supporting documents.	

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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F0164 SS=A	<p>Quality review 10/05/11 by Suzanne Williams, RN</p> <p>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>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. Based on observation and interview, the facility failed to provide an environment that maintained each resident's personal privacy regarding isolation precautions identifying the type of isolation were posted outside and on the residents' doors, for 2 of 2 random observations of residents with isolation precautions. (Resident #73</p>	F0164	<p><b>F 164 Personal Privacy/Confidentiality of Records.</b></p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F 164.</p> <p>I. To correct the deficient practice the facility will</p>	10/14/2011	

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	<p>and Resident #34)</p> <p>Findings include:</p> <p>1. On 9/28/11 at 2:20 p.m., a sign was observed posted on Resident #73's door and below the room number indicating, "Contact Precautions - Visitors please check in at nurse's station before entering."</p> <p>On 9-29-11 at 9:55 a.m., a sign was observed posted on Resident #73's door and below the room number that indicated "Contact precautions -Visitors please check in at nurse's station before entering." A container for isolation was noted in room.</p> <p>On 9/30/11 at 11:25 a.m., a sign was observed posted on Resident #73's door and below the room number that indicated "Contact precautions -Visitors please check in at nurse's station before entering."</p> <p>2. On 9/26/11 on 9:45 a.m., a sign was observed on Resident #34's door that indicated "Isolation- Visitors please check in at nurse's station before entering."</p> <p>Interview of the Infection Control Nurse on 9/30/11 at 2 p.m. indicated if a resident requires precautions a sign</p>		<p>maintain each resident's personal privacy regarding isolation precautions by placing a sign on the door of the resident's room that is in isolation that simply states "Visitors please check in at nurse's station prior to entering."</p> <p>II. This deficient practice affected 2 of 2 random observations of residents. 1) Complete removal of signage indicating type of isolation were removed and destroyed on 9/30/11. 2) New signage was created to instruct visitors to check in at nurse's station prior to entering the room. (See Attachment B). This was completed on 9/30/11. Currently the facility has no residents in isolation.</p> <p>III. The corrective action will be monitored to ensure the deficient practice will not recur by: 1) DON and Infection Control Nurse or designee will inspect the posting for every isolation case to ensure compliance. 2) Nursing and Housekeeping staff were in-serviced on proper posting. Staff education began on 9/30/11 and was completed on 10/14/11.</p> <p>IV. DON and Infection Control Nurse will be responsible. Completion Date: 10/14/11.</p>		

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F0356 SS=C	<p>will be placed indicating to see nurse, and what type of isolation.</p> <p>3.1-3(p)(2)</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>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"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <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"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <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, interview, and record review, the facility failed to prominently display the nurse staffing</p>	F0356	<p><b>F 356 Posted Nurse Staffing Information</b></p> <p>The facility respectfully submits the following plan of correction as</p>	10/14/2011

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	<p>data accessible to residents/visitors and in a readable format for 2 of 2 nurse staffing data displayed in the facility. This had the potential to affect all 85 residents.</p> <p>Findings include:</p> <p>1. The nurse staffing data was observed to be posted behind the nursing stations on the East and West wings during the initial tour on 9/26/11 at 9:30 a.m. The staffing was observed in a plastic sleeve and posted vertical with horizontal documentation.</p> <p>Interview of RN #3 on 9/26/11 at 9:30 a.m. identified the nurse staffing data was posted behind the nursing station.</p> <p>2. On 9/29/11 at 10:10 a.m., the nurse staffing data was observed posted on West wing behind the nursing station in a plastic sleeve. The nurse staffing data was documented horizontal but was posted vertically. The nurse staffing data was observed posted on East wing behind the nursing station on 9/29/11 at 10:12 A.M. The nurse staffing data was documented horizontally but was posted vertically in a plastic sleeve. The nurse staffing</p>		<p>credible allegation of compliance to the above mentioned regulation, prefix F 356.</p> <p>I. To correct the deficient practice the facility posted the required nurse staffing data in a clear and readable format in a prominent place readily accessible to residents and visitors on both nursing wings.</p> <p>II. This deficient practice had the potential to affect all 85 residents.</p> <p>III. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) The Daily Nurse Staffing Form is now posted horizontally with documentation written horizontally, effective 10/14/11. 2) The Daily Nurse Staffing Form is now posted daily outside of the nurses station in an area easily accessible to residents and visitors, including those in wheelchairs effective 10/14/11. 3) Nursing staff responsible for posting the daily documentation were educated on changes with education completed on 10/14/11.</p> <p>IV. The corrective action will be monitored to ensure the deficient practice will not recur by: 1) The DON or designee will monitor the posting daily for two weeks then weekly thereafter to ensure it continues to be posted in a prominent display accessible</p>		

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F0386 SS=E	<p>data was unable to be read while standing outside of the nursing station.</p> <p>3. On 9/30/11 at 11 a.m., the nurse staffing data was posted on the East and West wings behind the nursing stations. The information was posted vertically with documentation written horizontally. The information was posted inside of a plastic sleeve. The nurse staffing data was unable to be read while standing outside of the nursing station.</p> <p>Review of the facility's current policy and procedure titled "Posting of Daily Nurse Staffing Information" dated 3/11/2011 on 9/30 /11 at 2 p.m. indicated "...This posting will be placed in an area that is accessible to all visitors and residents, including those in wheelchairs..."</p> <p>3.1-13(a) The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. Based on record review and interview,</p>	F0386	<p>to residents and visitors and remains in a readable format. 2) Any issues identified will be corrected immediately. V. DON or Designee will be responsible. Completion Date: 10/14/11.</p> <p><b>F 386 Physician Visits-Review Care/Notes/Orders</b></p>	10/30/2011	

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	<p>the facility failed to ensure the physician signed resident orders timely for 17 of 40 residents reviewed in the stage 1 census sample. (Residents #'s 58, 104, 63, 36, 61, 46, 39, 22, 110 , 5, 118, 80, 34, 33, 75, 27, and 116)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the clinical record of Resident # 5 on 9/29/11 at 2 p.m. indicated the most recent physician's orders were signed 7/14/11.</li> </ol> <p>Interview of RN #2 /Unit Manager on 9/30/11 at 12:25 p.m. indicated the physician had not signed physician orders since 7/14/11 and that the orders should have been signed.</p> <ol style="list-style-type: none"> <li>Review of the clinical record of Resident # 110 on 9/30/11 at 11:45 a.m. indicated physician orders had not been signed since admission 5/30/11.</li> </ol> <p>Interview of RN #1/Unit Manager on 9/30/11 at 12 p.m. indicated the physician had not signed physician orders since admission 5/30/11 and that the orders should have been signed.</p>		<p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F 386.</p> <ol style="list-style-type: none"> <li>To correct the deficient practice the facility contacted all physicians with delinquent records on resident #'s 58, 104, 63, 36, 61, 46, 39, 22, 110, 5, 118, 80, 34, 33, 75, 27, and 116. Each physician will review, date and sign all physician orders and/or recapitulation of physician orders for those residents indicated. Completion date October 30, 2011.</li> <li>This deficient practice affected 17 of 40 residents reviewed in the stage 1 census sample.</li> <li>The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) The DON or designee will identify physician orders and/or recapitulation of physician orders at month end and flag them for physician review, date and signature monthly.</li> <li>The corrective action will be monitored to ensure the deficient practice will not recur by: 1) Each month for the next 6 months, then quarterly thereafter, the DON or designee will complete the Physicians Services Review Quality Assurance Tool to</li> </ol>	

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	<p>3. Review of the clinical record of Resident # 22 on 9/30/11 at 11:45 a.m. indicated the physician had not signed physician orders since 5/24/11.</p> <p>Interview of RN #1/Unit Manager on 9/30/11 at 12 p.m. indicated the physician had not signed physician orders since 5/24/11.</p> <p>4. Review of the clinical record of Resident # 39 on 9/30/11 at 11:45 a.m. indicated the physician had not signed physician orders since 5/24/11.</p> <p>Interview of RN #1/Unit Manager on 9/3/0/11 at 12 p.m. indicated the physician had not signed physician orders since 5/24/11.</p> <p>5. Review of the clinical record of Resident #46 on 9/29/11 at 2 p.m. indicated the physician had not signed physician orders since prior to January 2011. The January 2011 physician orders were not signed.</p> <p>Interview of RN #2/Unit Manager on 9/30/11 at 12:25 p.m. indicated physician orders had not been signed since prior to 1/2011 and that the orders should have been signed.</p>		<p>monitor and ensure compliance. (See Attachment A).</p> <p>2) Any issues identified will be corrected immediately. V. DON or designee will be responsible. Completion Date: October 30, 2011.</p>		

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	<p>6. Review of the clinical record of Resident # 61 on 9/29/11 at 2 p.m. indicated the physician had not signed physician orders since 4/2011.</p> <p>Interview of RN #2/Unit Manager on 9/30/11 at 12:25 p.m. indicated physician orders had not been signed since 4/2011 and that the orders should have been signed.</p> <p>7. Review of the clinical record of Resident #36 on 9/29/11 at 2 p.m. indicated the physician had not signed physician orders since prior to 1/2011.</p> <p>Interview of RN #2/Unit Manager on 9/30/11 at 12:25 p.m. indicated physician orders had not been signed since prior to 1/2011 and that the orders should have been signed.</p> <p>8. Review of the clinical record of Resident #63 on 9/29/11 at 2 p.m. indicated the physician orders had not been signed since 5/2011.</p> <p>Interview of RN #2/Unit Manager on 9/30/11 at 12:25 p.m. indicated physician orders had not been signed since 5/2011 and that the orders should have been signed.</p> <p>9. Review of the clinical record of Resident #58 on 09/30/11 at 9:30</p>			

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	<p>a.m. indicated the resident had no physician's orders which were signed by the resident's physician after March 2011.</p> <p>Interview of RN #2 on 9/30/11 at 2:30 p.m. indicated the resident's physician orders had not been signed since March 2011 and should have been signed.</p> <p>10. Review of the clinical record of Resident #104 on 09/30/11 at 9:45 a.m. indicated the resident had no signed physician's orders after May 2011.</p> <p>Interview of RN #2 on 9/30/11 at 2:30 p.m. indicated the resident's physician orders had not been signed since May 2011 and should have been signed.</p> <p>11. On 9/30/11 at 9:40 a.m. Resident #34's clinical record was reviewed. Physician's recapitulation of orders for June, July, August, and September were noted on the chart. The recapitulations were not signed or dated by the physician.</p> <p>On 9/30/11 at 9:50 a.m., Unit Manager #1 indicated the recapitulations had not been signed by the physician.</p>			

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	<p>12. On 9/30/11 at 9:30 a.m. Resident 80's clinical record was reviewed. Physician's recapitulation orders were noted on the clinical record for the months of May, June, July, August, and September. None of the recapitulation of physician's orders were signed or dated by the physician.</p> <p>The Unit Manger #1 was interviewed on 9/30/11 at 9:40 a.m. and indicated the orders were not signed.</p> <p>13. On 9/30/11 at 9:45 a.m. Resident #118's clinical record was reviewed. Physician's order recapitulations for July and August were noted on the record and not signed by the physician. Progress notes were noted for the resident by the physician dated 8/1/11 and 9/9/11.</p> <p>On 9/30/11 at 9:50 a.m. Unit Manager #1 indicated the physician's recapitulations had not been signed by the physician.</p> <p>14. Resident #75's clinical record was reviewed on 9/27/11 at 10 a.m. An admission date was noted of 9/23/09. Signed physician orders were lacking from January 2011 to present.</p> <p>During interview of RN #3 on 9/30/11</p>				

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	<p>at 10:15 a.m., the RN indicated, the physician had not signed updated orders since January 2011.</p> <p>15. Resident #27's clinical record was reviewed on 9/27/11 at 10:15 a.m. An admission date was noted of 1/14/11. The most recent signed physician update orders was dated 1/17/11.</p> <p>During interview of RN #3 on 9/30/11, the RN indicated the physician had not signed orders since 1/17/11.</p> <p>16. Resident #33's clinical record was reviewed on 9/27/11 at 10:30 a.m. An admission date was noted of 4/30/10. Physician's signed orders were lacking.</p> <p>During interview of RN #3 on 9/30/11 at 10:15 a.m., the RN indicated there were no signed physician orders.</p> <p>17. Resident #116's clinical record was reviewed on 9/27/11 at 10:45 a.m. An admission date was noted of 7/11/11. Signed physician's orders were noted, signed 9/15/11.</p> <p>During interview of RN #3 on 9/30/11 at 10:15 a.m., the RN indicated the only signed physicians orders were 9/15/11.</p>				

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	<p>Review of the facility's current policy and procedure titled "Physician visits and Activities" dated 10/20/2008 on 9/30/11 at 2 p.m. indicated "...A. Physicians consolidated orders (recaps) must be signed and dated every 30 days for the 1st 90 then every 60 days thereafter...."</p> <p>3.1-22(c)(3)</p>				