

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155173	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR - MARION	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N BRADNER AVE MARION, IN 46952
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 23, 24, 25, 28 and 29, 2014</p> <p>Facility number: 000089 Provider number: 155173 AIM number: 100287760</p> <p>Survey team: Angela Selleck, RN TC Kim Davis, RN Karen Koeberlein, RN Jason Mench, RN</p> <p>Census bed type: SNF: 10 SNF/NF: 97 Residential: 10 Total: 117</p> <p>Census payor type: Medicare: 15 Medicaid: 89 Other: 13 Total: 117</p> <p>Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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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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F000157 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>			

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	<p>Based on interview and record review, the facility failed to ensure the physician was notified in a timely manner, to report changes in a resident's condition regarding daily weight increases. This deficient practice had the potential to affect 1 of 30 residents residing in the facility whose physician orders were reviewed. (Resident's #9)</p> <p>Findings Include:</p> <p>The clinical record for Resident #9 was reviewed on 4/28/14 at 7:45 a.m. Diagnoses included, but were not limited to, ESRD (end stage renal disease), CHF (congestive heart failure), and depression. Resident #9 received hemo-dialysis 3 times per week as a treatment for kidney disease. Resident #9 had a current weight of 136 pounds (lbs) dated 4/27/14.</p> <p>A current physician order, dated 3/17/14, indicated Resident #9 was to receive a daily weight check each morning after voiding, before consuming breakfast or medications, and wearing the same type clothes each day. The daily weight was to be documented in Resident #9's clinical chart. The order also indicated the need to notify the physician if Resident #9 would have a 2 lb weight gain in 1 day, and or a 4 lb. weight gain in 5 days.</p>	F000157	<p>F157 Notify of Changes (Injury/Decline/Room, Etc.: It is the policy of Miller's Merry Manor, Marion to inform the resident, responsible party and the attending physician when there is a significant change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complications, including a need to alter treatment or discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. The physician of Resident #9 was notified of current weight status. Resident is receiving routine dialysis 3x weekly. She was monitored with daily weights for Dx of CHF. The facility was also entering the resident's weights post dialysis into the electronic medical record. Upon review this then showed significant fluctuations in the resident's weight status. The facility has been in contact with the NP overseeing care. Weight changes have been discussed and reviewed. New orders received for weight monitoring. Care plan has been updated accordingly. This deficient practice has the potential to affect all residents in the building. The facility has reviewed all residents with ordered daily weights and orders for perimeters to notify physician of changes. The facility will re-educate all licensed nursing staff regarding</p>	05/29/2014	

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	<p>During a review of Resident #9's daily weight record from 3/17/14 to 4/23/14, Resident #9 had multiple weight increases, where no documentation could be found indicating Resident #9's physician had been notified.</p> <p>12 lb. weight increase between 3/18/14 - 3/19/14. 12 lb. weight increase between 3/20/14 - 3/21/14. 16 lb. weight increase between 3/24/14 - 3/26/14. 5 lb. weight increase between 3/31/14 - 4/1/14. 5 lb. weight increase between 4/2/14 - 4/3/14. 16 lb. weight increase between 4/4/14 - 4/7/14. 8 lb. weight increase between 4/9/14 - 4/11/14. 5 lb. weight increase between 4/11/14 - 4/14/14. 5 lb. weight increase between 4/14/14 - 4/15/14. 12 lb. weight increase between 4/18/14 - 4/21/14.</p> <p>During an interview on 4/29/14 at 9:30 a.m., LPN #1 indicated Resident #9 was to be weighed daily by the night nurse upon waking, and prior to eating or drinking. LPN #1 had no explanation as to why the physician had not been</p>		<p>"Notification of Condition Changes" on 5-22-14. The facility will utilize the QA tool "24 Hour Report" (Attachment A) to monitor daily changes in resident conditions to ensure that proper notification is completed. This tool will be completed by the DON/Designee on a daily basis x2 weeks, then weekly x4 weeks and then monthly thereafter. Any identified issues will be addressed immediately. Concerns/Issues will be logged on the QA Summary Problem Log (Attachment B) and reviewed/revised monthly in the facility QA Meeting. Date of Compliance 5-29-14.</p>	

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F000282 SS=D	<p>notified of the weight fluctuations.</p> <p>A facility policy, dated 1/3/03, and obtained from the ADoN (Assistant Director of Nursing) on 4/29/14, at 9:42 a.m., titled, "Physician and Family Notification of Condition Changes" indicated:</p> <p>"A. Purpose 1. To keep the physician, resident, and family appraised of all condition changes...."</p> <p>"...b. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan..."</p> <p>3.1-5(a)(2)</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 interview and record review, the facility failed to ensure a resident, with a physician's order for a daily weight check, received the daily weight check for 1 of 2 residents residing in the facility receiving dialysis. (Resident #9)</p>	F000282	<p>F282 Services by Qualified Person/Per Care Plan: It is the policy of Miller's Merry Manor, Marion that all services provided or arranged by the facility will be provided by qualified persons in accordance with each residents</p>	05/29/2014
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	<p>Findings include:</p> <p>The clinical record for Resident #9 was reviewed on 4/28/14 at 7:45 a.m. The resident's diagnoses included, but were not limited to, ESRD (end stage renal disease), CHF (congestive heart failure), and depression. Resident #9 received hemo-dialysis 3 times per week as a treatment for kidney disease. Resident #9 had a current weight of 136 pounds (lbs) dated 4/27/14.</p> <p>A current physician order, dated 3/17/14, indicated Resident #9 was to receive a daily weight check each morning after voiding, before consuming breakfast or medications, and wearing the same clothes each day. The daily weight was to be documented in Resident #9's clinical chart.</p> <p>During review of Resident #9's daily weight record from 3/17/14 to 4/28/14, there was no daily weight documented in Resident #9's clinical record for the dates of 3/22/14, 3/25/14, 3/29/14, 4/5/14, 4/6/14, 4/10/14, 4/12/14, 4/13/14, 4/19/14, 4/20/14, and 4/26/14.</p> <p>During an interview on 4/29/14 at 9:30 a.m., LPN #1 indicated Resident #9 was to be weighed daily by the night nurse upon waking, and prior to eating or</p>		<p>written plan of care.</p> <p>The physician of Resident #9 was notified of current weight status. Resident is receiving routine dialysis 3x weekly. She was monitored with daily weights for Dx of CHF. The facility was also entering the resident's weights post dialysis into the electronic medical record. Upon review this then showed significant fluctuations in the resident's weight status. The facility has been in contact with the NP overseeing care. Weight changes have been discussed and reviewed. New orders received for weight monitoring. Care plan has been updated accordingly.</p> <p>This deficient practice has the potential to affect all residents in the building. The facility has reviewed all residents with ordered daily weights and orders for perimeters to notify physician of changes.</p> <p>The facility will re-educate all licensed nursing staff regarding documentation and notification of weights on 5-22-14.</p> <p>The facility will utilize the QA tool "24 Hour Report" (Attachment A) to monitor daily changes in resident conditions to ensure that proper notification is completed. This tool will be completed by the DON/Designee on a daily basis x2 weeks, then weekly x4 weeks</p>				

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F000318 SS=D	<p>drinking. LPN #1 had no explanation as to why the weights had not been obtained on the dates mentioned.</p> <p>During an additional interview with the DoN (Director of Nursing) on 4/29/14, at 3:30 p.m., the DoN was unable to provide a policy in regards to residents receiving a daily weight check.</p> <p>3.1-35(g)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with a contracture, received treatment according to physician orders for the contracture. This practice affected 1 of 3 residents residing in the facility with contractures.(Resident #66).</p> <p>Findings include:</p> <p>The clinical record for Resident #66 was reviewed on 4/25/14, at 9:29 a.m.</p> <p>Diagnoses included, but were not limited to, cerebral palsy, history of stroke, and</p>	F000318	<p>and then monthly thereafter. Any identified issues will be addressed immediately.</p> <p>Concerns/Issues will be logged on the QA Summary Problem Log (Attachment B) and reviewed/revise monthly in the facility QA Meeting.</p> <p>Date of Compliance: 5-29-14</p> <p>F 318 Increase/Decrease in Range of Motion: It is the policy of Miller's Merry Manor, Marion to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decreases in range of motion. Resident #66 had been utilizing a split to the left hand for contractures. On Monday 4-21-14 The nurse noticed the splint was not in place. Nurse spoke with therapy on Tuesday 4-22-14 and it was noted the splint was broken. Per therapy splint had not been effective due to increase in</p>	05/29/2014			

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	<p>depression.</p> <p>During review of physician orders on 4/25/14 at 9:30 a.m., Resident #66 had a current order with a start date of 1/2/14, for a splint to be placed on the left hand daily as a treatment for a contracture. The end date was listed as "indefinite". The order also indicated the splint was to be in place 3-3.5 hours daily, and staff were to monitor placement daily. The most recent careplan, dated 3/27/14, indicated Resident #66 was to be reminded each day to leave the splint in place.</p> <p>During an observation, on 4/23/14, at 11:30 a.m., Resident #66 was observed to have a left hand contracture. No splint was observed to be in place at that time on Resident #66's left hand. Additional observations conducted on 4/23/14 at 2:30 p.m., 4/24/14 at 10:00 a.m., 4/25/14 at 1:38 p.m., 4/28/14 at 9:30 a.m., and 4/29/14 at 7:40 a.m., found Resident #66 engaged in various activities without the splint in place on the left hand.</p> <p>During an interview on 4/24/14, at 10:05 a.m., Resident #66 indicated he had suffered a stroke causing the contracture to his left hand. Resident #66 also indicated the splint had not been placed on his hand for some time. The MDS (Minimum Data Set Assessment) for</p>		<p>tone of left upper extremity. Resident had botox injections in the past with noticeable improvements in tone, thus allowing better fitting for splint. Therapy suggested follow up with physician to inquire about possibly getting repeat injection for this and then they will see resident again afterwards to have another splint made. The splint was discontinued 4-23-14 . Currently a palm protector is in place to the left hand. Resident has been scheduled to have botox injection on June 5th with Dr. Hamdi. MD does not want new splint provided until after he sees him on June 5th. The physician also ordered Tizanidine for muscle tone. Resident and family are aware. Care plan has been updated. All residents requiring the use of splints/braces have the potential to be affected by this deficient practice. All have been reviewed to ensure devices are in place and care plans are appropriate. All staff will be inserviced on the use/need for splints and devices for contractures on 5-22-14. To ensure this deficient practice does not recur the DON/Designee will complete the audit tool "Devices and Splints"(Attachment C). This tool will be completed weekly for 4 weeks, then monthly for 2 months and then quarterly thereafter. All issues identified will be addressed immediately. Concerns will be documented on</p>		

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	<p>Resident #66, dated 3/27/14, indicated Resident #66 had no cognitive impairment.</p> <p>During an interview on 4/24/14 at 10:15 a.m., LPN #1 indicated Resident #66 previously had a splint in place, but that she had not seen the splint in place for several days. LPN #1 also indicated the splint had reportedly been broken, and was unsure how long Resident #66 had been without the splint. LPN #1 indicated the PTA (Physical Therapy Assistant) was responsible for placing the splint on Resident #66's hand.</p> <p>During an interview with PTA #6 on 4/24/14, at 10:20 a.m., PTA #6 indicated the splint for Resident #66's left hand had been broken and a new splint was on order. PTA #6 was unable to provide documentation of a new splint having been ordered for Resident #66.</p> <p>During an interview with the Director of Nursing (DoN) on 4/24/14, at 10:40 a.m., the DoN indicated being unable to provide a facility policy in regard to following physician orders in regard to splints.</p> <p>3.1-42(a) 3.1-42(2)</p>		the QA Problem Log. This will be followed through the QA Process at the monthly QA Meeting. Date of Compliance: 5-29-14				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall interventions to prevent falls were followed for 1 of 2 resident reviewed for falls. (Resident #54)</p> <p>Findings Include:</p> <p>The clinical record of Resident #54 was reviewed on 4/28/14 at 9:45 a.m. The record indicated the resident's diagnoses included, but were not limited to: venous insufficiency, chronic kidney disease, Benign Prostatic Hypertrophy (BPH), paralysis, osteoarthritis, and depressive disorder.</p> <p>The care plan, dated 3/5/14, indicated Resident #54 required extensive assistance with ADLs (Activities of Daily Living) due to vision impairment, memory deficiencies, and weakness. The care plan indicated the resident required assistance with toileting before and after meals and required the assistance of two staff members. The care plan indicated</p>	F000323	<p>F 323 Free of Accidents: It is the policy of Miller's Merry Manor, Marion to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident # 54 suffered no adverse effects related to this event. Care plan for fall risk has been reviewed and education provided for staff. All residents have the potential to be affected by this deficient practice. Care plans for residents identified as fall risks have been reviewed and updated as needed. All staff will be educated regarding fall prevention and ensuring care plan interventions to prevent accidents are followed at all times on 5-22-14. To ensure that this does not recur the DON/Designee will complete the QA Audit Tool "Fall Risk Management Review"(Attachment D). This will be completed 2x weekly for 2 weeks then weekly for 4 weeks then monthly thereafter. Any concerns will be addressed immediately and then logged on</p>	05/29/2014			

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	<p>Resident #54 was at risk for falls. The care plan interventions included "...don't elevate feet while in recliner..."</p> <p>Review of April 2014 nursing assessments indicated Resident #54 fell on 4/2/14, 4/6/14, 4/21/14, 4/22/14, 4/24/14, and 4/25/14.</p> <p>On 4/23/14 at 2:45 p.m. Resident #54 was observed sitting in his recliner with his feet completely elevated.</p> <p>On 4/24/14 at 9:23 a.m. Resident #54 was observed sitting in his recliner with his feet completely elevated.</p> <p>On 4/25/14 at 10:00 a.m. Resident #54 was observed sitting in his recliner with his feet completely elevated.</p> <p>On 4/28/14 at 10:30 a.m. Resident #54 was observed sitting in his recliner with his feet completely elevated.</p> <p>On 4/29/14 at 9:30 a.m. Resident #54 was observed sitting in his recliner with his feet completely elevated.</p> <p>Certified Nursing Assistant (CNA) #5 was interviewed on 4/29/14 at 9:30 a.m. During the interview the CNA indicated Resident #54 enjoyed sitting in the recliner to rest. CNA #5 indicated he</p>		<p>the QA Problem Log. This will be followed through the monthly QA Meeting. Date of Compliance: 5-29-14</p>				

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F000329 SS=D	<p>doesn't use his call light. "He will let us know when he's done napping by trying to come out of the chair."</p> <p>The Assistant Director of Nursing (ADoN) was interviewed on 4/29/14 at 12:30 p.m. During the interview the ADoN indicated she had written the fall intervention to not elevate the resident's feet when he was in the recliner. The ADoN indicated Resident #54 moved around in the chair and reached for the handle if the chair was back all the way. The ADoN indicated she thought this intervention would prevent the resident from falling out of the chair. The ADoN indicated she had not monitored staff to ensure the fall intervention was carried out.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>			

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR - MARION				STREET ADDRESS, CITY, STATE, ZIP CODE 505 N BRADNER AVE MARION, IN 46952			
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	<p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure Gradual Dose Reductions were completed for 2 of 5 residents reviewed for the use of unnecessary medication use. (Residents 54 and 9)</p> <p>Findings Include:</p> <p>1. The clinical record of Resident #54 was reviewed on 4/28/14 at 9:45 a.m. The record indicated the resident's diagnoses included, but were not limited to venous insufficiency, chronic kidney disease, Benign Prostatic Hypertrophy (BPH), paralysis, osteoarthritis, and depressive disorder.</p> <p>The physician orders included an order, dated 4/22/13, for 10 milligrams (mgs) of the antidepressant, Lexapro, to be given daily.</p>	F000329	<p>F329 Drug Regimen is free from unnecessary drugs: It is the policy of Millers Merry Manor, Marion to ensure that the resident's medication regimen helps promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Resident #9 and #54 have had no adverse effects as a result of this deficient practice. The above resident's have been reviewed by the interdisciplinary team and will continue to be reviewed to assure that medication therapy is based upon an adequate indication for use and that on-going monitoring of target mood indicators will be documented as they occur in the clinical record along with interventions used to reduce and the results of the interventions. Each resident who the attending physician or psychiatrist feels as though a gradual dose reduction would be contraindicated will be thoroughly documented on. The documentation will include the</p>	05/29/2014			

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	<p>The care plan, dated 3/5/14, indicated Resident #54 had a diagnosis of depression. The care plan interventions included medication administration, resident support, listen to the resident's concerns, and notify the physician with updates as needed.</p> <p>Further review of the resident's clinical record indicated no reduction of the antidepressant had been attempted.</p> <p>The Social Service Designee (SSD) was interviewed on 4/22/14 at 10:15 a.m. The SSD indicated a reduction of the antidepressant had not been attempted for over a year for Resident #54.</p> <p>The Director of Nursing (DoN) was interviewed on 4/29/14 at 1:30 p.m. The DoN indicated the facility had recently started working on the reduction of antidepressant medications in the facility. The DoN indicated Resident #54's antidepressant had not been reduced. 2. The clinical record for Resident #9 was reviewed on 4/25/14 at 1:12 p.m. Diagnoses included, but were not limited to, ESRD (End Stage Renal Disease), CHF (Congestive Heart Failure), and depression.</p> <p>During review of physician orders on 4/25/14, at 1:25 p.m., Resident #9 had a</p>		<p>clinical rationale for why any additional attempted dose reductions at that time would be likely to impair the resident's function, increase distressing behavior or cause psychiatric instability by exacerbating an underlying psychiatric conditions. All residents have the potential to be affected by this deficient practice. All residents on psychoactive medications have been reviewed to ensure there is a schedule for gradual dose reductions in place unless clinically contraindicated by the physician/psych provider. The facility had been reviewing all psychoactive medications including antidepressants beginning 4-9-14. Multiple medication reductions had been made. This information was provided to the survey team. The facility's psych provider and primary care physicians have been re- educated on F329 regulation and survey citation. We will continue to use the Summary of OBRA psychoactive and hypnotic regulations to assess for appropriate indications and ongoing need of psychoactive medications. IDT have reviewed the policies regarding psychotropic drug use. All resident's who have a psychotropic medication will be tracked and reviewed monthly by the IDT utilizing the tool "Psychopharmacological Medications" (Attachment F). A</p>	

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	<p>current physician order for Zoloft (an anti-depressant) 25 mg once daily, to be administered at 9:00 p.m. The anti-depressant Zoloft had an original start date of 11/2/12.</p> <p>During an observation on 4/25/14, at 3:00 p.m., Resident #9 was lying in her room sleeping. Additional observations on 4/28/14 at 2:35 p.m., and 4/29/14 at 10:14 a.m., also found Resident #9 asleep in her room during daytime hours.</p> <p>During an interview on 4/25/14, at 2:15 p.m., the DoN (Director of Nursing) indicated there had never been an attempted gradual dose reduction since Resident #9 had been prescribed Zoloft in 11/2012. The DoN also indicated Resident #9 had recently had a death in the family, and did not feel it would be appropriate at this time to attempt a GDR (gradual dose reduction).</p> <p>During an additional interview with the DoN on 4/29/14, at 11:00 a.m., the DoN indicated having no behavior tracking information to provide in regards to depression for Resident #9. The DoN also indicated behavior tracking was not completed for the use of anti-depressants.</p> <p>3. The facility policy entitled "PSYCHOTROPIC MEDICATION</p>		<p>mandatory in-service will be conducted on 5-22-14 in which the psychotropic drug use policy will be discussed with all staff. The facility will continue to conduct monthly behavior meetings with IDT present. During this time all residents receiving psychoactive medications will be reviewed to ensure there is a schedule for gradual dose reductions in place. We will continue to use the Summary of OBRA psychoactive and hypnotic regulations to assess for appropriate indications and ongoing need of psychoactive medications. To ensure that this deficient practice does not re-occur SSD or her designee will monitor all residents with psychotropic drug use utilizing the QA tool "Behavior and Psychotropic Medication Review" (Attachment E) weekly x 1 month, bi-weekly x 1 month, and monthly x 4 months and then quarterly thereafter. Any issues noted will be corrected immediately and then concerns will be logged on the QA summary log and reviewed and followed through the facility monthly QA meeting. Date of Compliance 5-29-14.</p>		

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F000441 SS=D	<p>USE", dated 2/4/2008, was presented by the Director of Nursing (DoN) on 4/29/14 at 9:45 a.m. The policy indicated "... Gradual Dose Reductions (GDR) will be attempted, unless clinically contraindicated, in an effort to discontinue these drugs..."</p> <p>3.1-48(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or</p>						

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	<p>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, interview, and record review, the facility failed to ensure personal care was performed in a manner in which to prevent the spread of infection for 1 of 1 resident with 2 of 2 Certified Nursing Assistants (CNA) observed for personal care during 1 of 1 direct care observations. (Resident # 54) (CNA #s 4 and 5)</p> <p>Findings Include:</p> <p>The clinical record of Resident #54 was reviewed on 4/28/14 at 9:45 a.m. The record indicated the resident's diagnoses included, but were not limited to: venous insufficiency, chronic kidney disease, Benign Prostatic Hypertrophy (BPH), paralysis, osteoarthritis, and depressive disorder.</p> <p>The care plan, dated 3/5/14, indicated Resident #54 required extensive assistance with ADLs (Activities of Daily Living (due to vision impairment,</p>	F000441	<p>F441 Infection Control: It is the policy of Miller's Merry Manor, Marion to establish and maintain an Infection Control Policy designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Resident #54 suffered no adverse effects related to this deficient practice. All residents have the potential to be affected by this deficient practice. No other issues have been identified. C.N.A. #4 and #5 were re-educated regarding hand washing, glove use and procedure for peri-care. Education will be provided to all staff on 5-22-14 to review infection control policies with focus on handwashing and glove useage. All CNAs will be skill checked and will perform return demonstartions for peri-care. The facility does provide routine education per on line inservices (Silverchair) and face to face education on infection control. Routine skill checks are also</p>	05/29/2014

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	<p>memory deficiencies, and weakness. The Care Plan indicated the resident required assistance with toileting before and after meals and required the assistance of two staff members.</p> <p>Toileting assistance was observed on 4/29/14 at 8:55 a.m. with Resident #54 and CNA #4 and CNA #5. CNA #4 put a bath towel under running water in the bathroom sink and added soap. CNA #5 assisted Resident #54 by the wheelchair into the bathroom. Both staff donned disposable gloves.</p> <p>The CNAs assisted the resident to hold onto the grab bar across from the toilet and stand. The CNAs pulled down the resident's pants and helped him sit on the toilet. CNA #4 indicated the resident had BM (bowel movement) in the brief and on his buttocks. CNA #4 removed the soiled brief and disposed of it in a trash bag. CNA #5 changed her gloves. CNA #4 did not. CNA #4 put a clean brief loosely around the resident's ankles as he sat on the toilet.</p> <p>The CNAs assisted Resident #54 to stand. CNA #4 took the wet, soapy towel from the sink and began to wash the BM off the resident's buttocks. The CNA wiped the BM, folded the towel to a clean area, wiped the BM, folded the</p>		<p>done for handwashing and peri-care. Skill checks for staff on handwashing will be completed monthly for the next three months. To ensure that infection control measures are followed according to P/P the QA Tool "Infection Control Review" (Attachment G) will be completed by the Infection Control Nurse/Designee weekly for the next four weeks then twice a month for the next two months then monthly thereafter. This tool will include observation of staff during resident care procedures to ensure that gloves are worn accordingly and handwashing is completed as outlined in the facility infection control policy. Any identified issues will be addressed immediately. Concerns will be logged on the "Quality Assurance Problem Log" (Attachment B). All Quality Assurance Problem Logs are reviewed and followed by the QA Committee in the monthly facility Quality Assurance Meeting. Date of Compliance: 5-29-14</p>				

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	<p>towel to another clean area, wiped the BM, and folded the towel to another clean area. This process continued with the same towel until the BM was washed off.</p> <p>CNA #4 then handed the dirty towel to CNA #5 to wash the resident's penis and scrotum. As she did, BM fell out of the towel onto the floor and toilet seat.</p> <p>CNA #5 indicated to CNA #4 that there was no BM on the resident's penis and scrotum. CNA #5 handed the towel back to CNA #4. The resident's penis was not washed.</p> <p>CNA #5 removed her gloves. CNA #4 did not. The CNAs then pulled up the resident's clean brief and pants and assisted to sit back down in the wheelchair.</p> <p>CNA #5 assisted the resident out of the bathroom back into the bedroom. CNA #4 pulled a clean towel from the sink and wiped the BM from the toilet seat and floor. CNA #4 removed her gloves. The two CNAs assisted the resident from the wheelchair to the recliner chair.</p> <p>CNA #4 was interviewed on 4/29/14 at 9:15 a.m. The CNA indicated she did not change her gloves during the procedure.</p>			

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	<p>The CNA indicated " I know I didn't because they were sweating off my hands."</p> <p>The Director of Nursing (DoN) was interviewed on 4/29/14 at 12:30 p.m. During the interview, the DoN indicated CNA #1 should have changed her gloves when they were dirty. The DoN indicated a towel should not have been used to wash the resident.</p> <p>The facility policy entitled, "Peri Care" dated 1/1/2009 was presented by the DoN on 4/29/14 at 9:45 a.m. The policy indicated "... 3. PROCEDURE... N. Male: Wash from front to back, using soap product and a wet washcloth. Be certain to pull the foreskin of the penis back for cleansing (if male is uncircumcised). Rinse and dry completely... Q. Remove gloves and wash hands..."</p> <p>The facility policy entitled "Use of Medical Gloves (application and removal) dated 6/9/2010 was presented by the DoN on 4/29/14 at 4:00 p.m. The policy indicated, "... C. Gloves should not be used as a substitute for hand-washing. D. Gloves should be used for hand contaminating activities, handling soiled linen, when touching blood, body fluids, secretions, excretions, mucous</p>						

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	<p>membranes and non intact skin... E. Gloves should be removed and hands washed between care activities with patients..."</p> <p>The facility policy entitled " Hand Washing and Hand Asepsis" dated 7/27/2012 was presented by the DoN on 4/29/14 at 4:00 p.m. The policy indicated, " ...6. HAND-WASHING SHOULD BE DONE IF VISIBLE SOILING IS PRESENT."</p> <p>3.1-18(I)</p>				