

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/18/2012
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 5909 LUTE RD PORTAGE, IN 46368
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 11, 12, 13, 14, 17 and 18, 2012</p> <p>Facility number: 000196 Provider number: 155299 AIM number: 100267390</p> <p>Survey team: Kathleen (Kitty) Vargas, RN-TC Lara Richards, RN Heather Tuttle, RN</p> <p>Census bed type: SNF: 2 SNF/NF: 63 Total: 65</p> <p>Census payor type: Medicare: 18 Medicaid: 35 Other: 12 Total: 65</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/20/12 Cathy Emswiller RN</p>	F0000	Please accept the following plan of correction as our credible allegation of compliance.	

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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F0157 SS=D	<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> <p>Based on record review and interview, the facility failed to ensure the Physician and Responsible Party were notified of an alleged abuse for 1 of 3 abuse allegations reviewed</p>	F0157	It is the policy of Miller's Merry Manor, Portage to ensure that the physician and responsible party are notified of any resident allegations of abuse. – Res #70 The resident's physician and	01/17/2013			

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	<p>related to an alleged verbal abuse and rough handling. (Resident #70)</p> <p>Findings include:</p> <p>On 12/18/12 at 11:00 a.m., an allegation of alleged verbal abuse and rough handling for Resident #70 was reviewed. The alleged incident occurred on 11/11/12 at 1:30 p.m. Review of the information that was faxed to the State Agency, indicated it was reported to the Charge Nurse that CNA #2 was allegedly talking inappropriately to BNA #1, while in the presence of the resident. It was alleged that CNA #2 was using poor technique to transfer the resident.</p> <p>Review of the summary of the facility investigation indicated, it was alleged on 11/11/12 that CNA #2 used an inappropriate phrase in front of the resident while providing care. It was also alleged the CNA did not use enough care in the hooyer transfer process and the resident's legs swung around and hit the hooyer bar. The Administrator and Director of Nursing completed the investigation process. The involved resident was interviewed and she stated that she had not had any problems with anyone caring for her in this facility. She does not recall anyone using an</p>		<p>family were notified on 12/18/12 @ 2pm. Any future allegations of abuse will be investigated per policy and promptly notify the physician and family per policy. All residents are at risk to be affected by the deficient practice. An all nursing staff in-service is scheduled for 1/7/13 to review the facility policy for "Physician and Family Notification of Change" (Attachment A). Nursing will be educated that any resident allegation of abuse shall be considered a significant change in status and must be reported to the responsible party and physician per policy. The charge nurse or other designee will be responsible to document the notification on the 24hour report sheet along with a head to toe skin assessment. The 24 hour report sheet serves as the communication device utilized by charge nurses to deliver report upon completion of shift and for the oncoming shift. The 24hour report sheets are routinely reviewed by the DON and Administrator M-F, and the department head manager on the weekends to identify for any significant changes in resident status and to monitor that notification to responsible party and physician occurs per policy. The DON or other designee will be responsible to complete the quality assurance tool titled " 24 Hour Condition Report" (Attachment B) daily for 1</p>		

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	<p>inappropriate phrase in her presence. The resident stated all staff have to be careful with her legs during hoyer process because she has had a stroke and no control of her leg. She denied anyone was rough with her. She stated she felt well cared for in this facility. The CNA was interviewed and denied using a rude phrase. No other residents on that pod (unit) voiced any concerns with care provided by CNA #2. Allegation of inappropriate treatment was unsubstantiated. The CNA will be given education in regards to resident rights and hoyer use to ensure on-going proper procedures. She will return to work once education is completed.</p> <p>Review of additional investigation provided by the Administrator, indicated there was no written statement from the employee who was accused and there was no documentation of the conversation between the Director of Nursing and BNA #1. Further, there was no documentation of the resident's Physician and Responsible Party being notified of the alleged incident. Record review on 12/18/12 at 11:30 a.m., indicated an "Initial Occurrence Report" had not been completed in the electronic medical record.</p>		<p>week then 3x weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter to ensure ongoing compliance. Any identified issues will be documented on quality assurance tracking log. Any issues recorded on the facility tracking log will be reviewed during the monthly Quality Assurance meeting to ensure ongoing compliance.</p>		

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	<p>Review of the facility policy titled "Abuse Prohibition, Reporting, and Investigation" provided by the Director of Nursing and identified as current on 12/18/12 at 10:00 a.m., indicated the following "Resident Abuse Procedure":</p> <ul style="list-style-type: none"> <li>-The nurse will immediately examine and assess the resident(s) to determine if any injuries have occurred and their extent.</li> <li>-The attending physician(s) will be notified as soon as feasible, and any orders will be noted and initiated.</li> <li>-The family of the resident/residents will be notified as soon as feasible, but at most within 24 hours.</li> <li>-The investigation summary compiled by the Administrator or designee may include, but is not limited to: <ul style="list-style-type: none"> <li>-facts and observations from the involved employee or employees</li> <li>-injuries or lack thereof based upon the nursing assessment following the incident.</li> </ul> </li> <li>-An Incident Report will be completed following the guidelines in the "Unusual Occurrence Reporting Policy and Procedure" located in the Nursing Policy and Procedure manual. A nurses' note entry including a description of the incident, action taken and injuries assessed</li> </ul>			

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	<p>will be documented via Incident Occurrence assessment.</p> <p>Interview with the Director of Nursing on 12/18/12 at 11:50 a.m., indicated the resident's Physician and Responsible Party should have been notified.</p> <p>3.1-5(a)(2)</p>				

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F0164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <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.</p> <p>Based on observation and interview, the facility failed to ensure personal privacy and confidentiality related to staff discussing the medical status of residents while not in a private area for 1 of 1 confidential interviews and for 1 of 1 observed staff conversations.</p>	F0164	It is the policy of Miller's Merry Manor, Portage that the resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Miller's Merry Manor, Portage will ensure personal privacy and confidentiality related to staff discussing the medical status of residents is completed in a	01/17/2013	

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	<p>Findings include:</p> <p>1. A confidential interview with a resident's family member on 12/11/12 at 3:49 p.m., indicated the nursing staff did not speak privately when they discussed the resident's medical status.</p> <p>She indicated the discussions with staff occurred in the center area of the unit in front of the resident's room. The center of the unit was the lounge area with tables, chairs and couches where residents attended activities, put puzzles together and visited with family members and other residents.</p> <p>She indicated the conversations with staff about her family member could be overheard by others.</p> <p>2. On 12/12/12 at 1:58 p.m., the Admission Director and the Administrator were observed in the hall next to the Nurses' Station. The Admission Director was relaying information to the Administrator about the status of discharged residents. She was informing him of residents who were hospitalized using their names. The conversation could be heard 25 feet away, in the Inservice Office, where non-staff members</p>		<p>manner in which promotes both privacy and confidentiality. Resident specific information regarding medical status or other resident personal privacy information will be discussed in a private area. The SSD or other designee will review the facility's plan of action to ensure privacy and dignity at the next Resident Council meeting scheduled in January 2013. All residents in the facility have the potential to be affected by this deficient practice. An all staff in-service will be held on 1/7/13 to review "Resident Rights" with an emphasis on resident privacy and knocking on resident doors and awaiting permission prior to entering. The staff will be re-educated on the importance of sharing medical status or other resident personal privacy information in a private area to ensure confidentiality and privacy. Facility department heads participate in routine quality assurance/satisfaction calls to facilitate expression of any resident concerns. The team will be instructed to inquire about resident privacy/dignity at next QA call. Any concerns will be documented on a quality assurance log and addressed immediately. The QA logs will be shared at the facility monthly quality assurance meeting. The administrator, nursing managers, and other department heads will participate in random walking</p>		

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	<p>could hear the conversation. Other residents were in the vicinity and could potentially hear the conversation also.</p> <p>Interview with the Admission Director on 12/18/12 at 8:45 a.m., indicated she did not recall speaking with the Administrator on 12/12/12 near the Nurses Station. She indicated the facility was small and speaking privately to staff in the facility was difficult.</p> <p>Interview with the Administrator on 12/18/12 at 9:05 a.m., indicated the facility was space challenged. He indicated it was important to maintain confidentiality for the residents.</p> <p>3.1-3(p)(2)</p>		<p>rounds of units to observe that staff are not overheard discussing private resident information in non-private areas and that staff are knocking on resident doors and awaiting reponse from resident prior to entering rooms. The Social Services Director or other designee will be responsible to complete the qa tool titled "Quality of Life/Dignity Review" (Attachment C) to observe no less than 5 resident per evaluation period as follows: Tool will be completed daily for 1 week, then bi weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter. The tool will be used during all three shifts and at different times. Any concerns will be documented by the Social Services Director or designee and addressed immediately. Resident's will be able to express concerns at any time including the monthly resident council meeting. Any concerns will be documented by the Social Service Director or designee. Any concerns identified will be addressed immediately and recorded on a QA tracking log. Any issues documented on QA tracking log will be reviewed in the monthly QA meeting to monitor and ensure ongoing complianc</p>		

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F0225	It is the policy of Miller's Merry	01/17/2013			

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	<p>interview, the facility failed to ensure 1 of 3 abuse allegations reviewed were thoroughly investigated related to an alleged verbal abuse and rough handling. (Resident #70) The facility also failed to ensure an infectious outbreak was reported to the State Agency.</p> <p>Findings include:</p> <p>1. On 12/18/12 at 11:00 a.m., an allegation of alleged verbal abuse and rough handling for Resident #70 was reviewed. The alleged incident occurred on 11/11/12 at 1:30 p.m. Review of the information that was faxed to the State Agency, indicated it was reported to the Charge Nurse that CNA #2 was allegedly talking inappropriately to BNA (Basic Nurse Aide) #1, while in the presence of the resident. It was alleged that CNA #2 was using poor technique to transfer the resident. There was no injury. The resident in question was interviewed on 11/13/12 and reported to the Social Service Director that this incident did not happen. The CNA was allowed to make a statement and placed on suspension pending investigation.</p> <p>Review of the summary of the facility investigation indicated, it was alleged</p>		<p>Manor, Portage to ensure abuse allegations are thoroughly investigated. The facility also has policies in place to ensure that infectious outbreaks that exceed 25% infection are reported to the ISDH. Resident #70: any future allegations of abuse will be thoroughly investigated. Family and physician will be notified of allegation/investigation. Facility infectious outbreaks affecting 25% or more of the resident population will be reported per policy to the ISDH. PLEASE SEE F_TAG 441 for the plan, who is at risk to be affected, and quality assurance system. All residents are at risk to be affected by the deficient practice. All staff are trained on the facility policy and procedures for "Abuse Prohibition, Reporting, and Investigation" upon hire and at least every 6 months. An all staff in-service will be provided to all staff regarding "Abuse Prohibition, Reporting, and Investigation" by 1/17/13. Nursing will be educated that any resident allegation of abuse shall be considered a significant change in status and must be reported to the responsible party and physician per policy. The charge nurse or other designee will be responsible to document the notification on the 24hour report sheet along with a head to toe skin assessment of the residents involved. The 24 hour report sheet serves as the</p>		

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	<p>on 11/11/12 that CNA #2 used an inappropriate phrase in front of the resident while providing care. It was also alleged the CNA did not use enough care in the hoyer transfer process and the resident's legs swung around and hit the hoyer bar. The Administrator and Director of Nursing completed the investigation process. The involved resident was interviewed and she stated that she had not had any problems with anyone caring for her in this facility. She does not recall anyone using an inappropriate phrase in her presence. The resident stated all staff have to be careful with her legs during hoyer process because she has had a stroke and no control of her leg. She denied anyone was rough with her. She stated she felt well cared for in this facility. The CNA was interviewed and denied using a rude phrase. No other residents on that pod (unit) voiced any concerns with care provided by CNA #2. Allegation of inappropriate treatment was unsubstantiated. The CNA will be given education in regards to resident rights and hoyer use to ensure on-going proper procedures. She will return to work once education is completed.</p> <p>Review of additional investigation</p>		<p>communication device utilized by charge nurses to deliver report upon completion of shift and for the oncoming shift. The 24hour report sheets are routinely reviewed by the DON and Administrator M-F, and the department head manager on the weekends to identify for any significant changes in resident status and to monitor that notification to responsible party and physician occurs per policy. Facility staff will be educated to report allegations of abuse to the administrator or other designee immediately. An investigation will be immediately initiated and directed by the administrator or designee and a detailed report will be forwarded to the ISDH within 5 days. The investigation will be summarized, signed, and dated and kept as evidence of the facility's investigation by the administrator or other designee. The "Abuse Investigation Worksheet" (Attachment D) will be utilized by the administrator or other designee with each abuse allegation to ensure all components of a thorough investigation is completed per facility policy. The tool will be completed prior to submitting the final 5day summary of investigation to the ISDH for the next 6months. Any areas not completed per policy will be corrected/investigated and then logged on a QA tracking log. The QA tracking logs will be brought</p>		

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	<p>provided by the Administrator, indicated there was no written statement from the employee who was accused and there was no documentation of the conversation between the Director of Nursing and BNA #1.</p> <p>Interview with the Director of Nursing on 12/18/12 at 11:50 a.m., indicated that she talked to the BNA who made the allegation, however, she indicated that documentation was not available.</p> <p>2. Review of the 2012 Infection Control Log on 12/18/12 at 10:05 a.m., indicated there was an outbreak of gastrointestinal infections in the month of June 2012. The log indicated there were a total of 28 residents who had symptoms of a gastrointestinal infection, that included nausea, vomiting and diarrhea. The census for that month was 56 residents. The percentage of residents who exhibited gastrointestinal symptoms was 50%.</p> <p>The symptoms were first noted on 6/22/12 and continued through 6/26/12.</p> <p>Interview with the Director of Nursing on 12/18/12 at 12:05 p.m., indicated</p>		to the monthly QA meeting for review and to monitor for ongoing compliance.		

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	<p>the outbreak was reported to the Indiana State Department of Health on 6/22/12.</p> <p>The form titled, "Facility Incident Report Form" dated 6/22/12, was reviewed. It indicated: "Brief Description of Incident: 19% of facility residents have developed nausea, vomiting, and diarrhea. One entire unit is free of any GI (gastro-intestinal) symptoms and have received the same meals from dietary that other units have received (therefore this is not dietary related).</p> <p>The immediate action taken were: 1. Residents are being kept on their respective units. Meals and activities will be provided on the units until the unit is free of symptoms. 2. Dietary interventions have been initiated i.e., jello, 7 up, broth, Gatorade, etc available. 3. Staff has been re-educated on importance of handwashing to prevent further spread of infection. 4. Staff re-educated to monitor effected residents for indications of dehydration 5. Families and physicians have been notified of residents with illness.</p> <p>Preventative measures taken: Corporate dietitian and corporate</p>			

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	<p>Quality Assurance nurse notified of event. Visitors are being asked to refrain from visiting until symptoms resolved."</p> <p>Interview with the Director of Nursing on 12/18/12 at 1:01 p.m., indicated the report was not sent to the Indiana State Department of Health. She indicated she thought the information was sent to Indiana State Department of Health by the Administrator and he thought the Director of Nursing had sent the report.</p> <p>3.1-28(d)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the abuse policy was followed as written, related to obtaining employee statements, performing an assessment of the resident, and Physician and Responsible Party notification for 1 of 3 abuse allegations reviewed related to an alleged verbal abuse and rough handling. (Resident #70) The facility also failed to ensure an infectious outbreak was reported to the State Agency.</p> <p>Findings include:</p> <p>1. On 12/18/12 at 11:00 a.m., an allegation of alleged verbal abuse and rough handling for Resident #70 was reviewed. The alleged incident occurred on 11/11/12 at 1:30 p.m. Review of the information that was faxed to the State Agency, indicated it was reported to the Charge Nurse that CNA #2 was allegedly talking inappropriately to BNA #1, while in the presence of the resident. It was</p>	F0226	<p>It is the policy of Miller's Merry Manor, Portage to ensure abuse allegations are thoroughly investigated. The facility also has policies in place to ensure that infectious outbreaks that exceed 25% infection are reported to the ISDH. Resident #70: any future allegations of abuse will be thoroughly investigated. Family and physician will be notified of allegation/investigation. Facility infectious outbreaks affecting 25% or more of the resident population will be reported per policy to the ISDH. PLEASE SEE F_TAG 441 for the plan, who is at risk to be affected, and quality assurance system. All residents are at risk to be affected by the deficient practice. All staff are trained on the facility policy and procedures for "Abuse Prohibition, Reporting, and Investigation" upon hire and at least every 6 months. An all staff in-service will be provided to all staff regarding "Abuse Prohibition, Reporting, and Investigation" by 1/17/13. Nursing will be educated that any resident allegation of abuse shall be considered a significant change in status and must be reported to</p>	01/17/2013			

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	<p>alleged that CNA #2 was using poor technique to transfer the resident.</p> <p>Review of the summary of the facility investigation indicated, it was alleged on 11/11/12 that CNA #2 used an inappropriate phrase in front of the resident while providing care. It was also alleged the CNA did not use enough care in the hoyer transfer process and the resident's legs swung around and hit the hoyer bar. The Administrator and Director of Nursing completed the investigation process. The involved resident was interviewed and she stated that she had not had any problems with anyone caring for her in this facility. She does not recall anyone using an inappropriate phrase in her presence. The resident stated all staff have to be careful with her legs during hoyer process because she has had a stroke and no control of her leg. She denied anyone was rough with her. She stated she felt well cared for in this facility. The CNA was interviewed and denied using a rude phrase. No other residents on that pod (unit) voiced any concerns with care provided by CNA #2. Allegation of inappropriate treatment was unsubstantiated. The CNA will be given education in regards to resident rights and hoyer use to ensure</p>		<p>the responsible party and physician per policy. The charge nurse or other designee will be responsible to document the notification on the 24hour report sheet along with a head to toe skin assessment of the residents involved. The 24 hour report sheet serves as the communication device utilized by charge nurses to deliver report upon completion of shift and for the oncoming shift. The 24hour report sheets are routinely reviewed by the DON and Administrator M-F, and the department head manager on the weekends to identify for any significant changes in resident status and to monitor that notification to responsible party and physician occurs per policy. Facility staff will be educated to report allegations of abuse to the administrator or other designee immediately. An investigation will be immediately initiated and directed by the administrator or designee and a detailed report will be forwarded to the ISDH within 5 days. The investigation will be summarized, signed, and dated and kept as evidence of the facility's investigation by the administrator or other designee. The "Abuse Investigation Worksheet" (Attachment D) will be utilized by the administrator or other designee with each abuse allegation to ensure all components of a thorough investigation is completed per</p>		

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	<p>on-going proper procedures. She will return to work once education is completed.</p> <p>Review of additional investigation provided by the Administrator, indicated there was no written statement from the employee who was accused and there was no documentation of the conversation between the Director of Nursing and BNA #1. Further, there was no documentation of the resident's Physician and Responsible Party being notified of the alleged incident. Record review on 12/18/12 at 11:30 a.m., indicated an "Initial Occurrence Report" had not been completed in the electronic medical record.</p> <p>Review of the facility policy titled "Abuse Prohibition, Reporting, and Investigation" provided by the Director of Nursing and identified as current on 12/18/12 at 10:00 a.m., indicated the following "Resident Abuse Procedure":</p> <ul style="list-style-type: none"> <li>-The nurse will immediately examine and assess the resident(s) to determine if any injuries have occurred and their extent.</li> <li>-The attending physician(s) will be notified as soon as feasible, and any orders will be noted and initiated.</li> </ul>		<p>facility policy. The tool will be completed prior to submitting the final 5day summary of investigation to the ISDH for the next 6months. Any areas not completed per policy will be corrected/investigated and then logged on a QA tracking log. The QA tracking logs will be brought to the monthly QA meeting for review and to monitor for ongoing compliance.</p>		

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	<p>-The family of the resident/residents will be notified as soon as feasible, but at most within 24 hours.</p> <p>-The investigation summary compiled by the Administrator or designee may include, but is not limited to:</p> <ul style="list-style-type: none"> <li>-facts and observations from the involved employee or employees</li> <li>-injuries or lack thereof based upon the nursing assessment following the incident.</li> </ul> <p>-An Incident Report will be completed following the guidelines in the "Unusual Occurrence Reporting Policy and Procedure" located in the Nursing Policy and Procedure manual. A nurses' note entry including a description of the incident, action taken and injuries assessed will be documented via Incident Occurrence assessment.</p> <p>Interview with the Director of Nursing on 12/18/12 at 11:50 a.m., indicated the resident's Physician and Responsible Party should have been notified. She also indicated an assessment had not been completed in the resident's medical record.</p> <p>Findings include:</p> <p>Review of the 2012 Infection Control Log on 12/18/12 at 10:05 a.m.,</p>			

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	<p>indicated there was an outbreak of gastrointestinal infections in the month of June 2012. The log indicated there were a total of 28 residents who had symptoms of a gastrointestinal infection, that included nausea, vomiting and diarrhea. The census for that month was 56 residents. The percentage of residents who exhibited gastrointestinal symptoms was 50%.</p> <p>The symptoms were first noted on 6/22/12 and continued through 6/26/12.</p> <p>Interview with the Director of Nursing on 12/18/12 at 12:05 p.m., indicated the outbreak was reported to the Indiana State Department of Health on 6/22/12.</p> <p>The form titled, "Facility Incident Report Form" dated 6/22/12, was reviewed. It indicated: "Brief Description of Incident: 19% of facility residents have developed nausea, vomiting, and diarrhea. One entire unit is free of any GI (gastro-intestinal) symptoms and have received the same meals from dietary that other units have received (therefore this is not dietary related).</p> <p>The immediate action taken were: 1.</p>						

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	<p>Residents are being kept on their respective units. Meals and activities will be provided on the units until the unit is free of symptoms. 2. Dietary interventions have been initiated i.e., jello, 7 up, broth, Gatorade, etc available. 3. Staff has been re-educated on importance of handwashing to prevent further spread of infection. 4. Staff re-educated to monitor effected residents for indications of dehydration 5. Families and physicians have been notified of residents with illness.</p> <p>Preventative measures taken: Corporate dietitian and corporate Quality Assurance nurse notified of event. Visitors are being asked to refrain from visiting until symptoms resolved."</p> <p>Interview with the Director of Nursing on 12/18/12 at 1:01 p.m., indicated the report was not sent to the Indiana State Department of Health. She indicated she thought the information was sent to Indiana State Department of Health by the Administrator and he thought the Director of Nursing had sent the report.</p> <p>3.1-28(a)</p>						

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 1 residents reviewed for dignity of the 1 resident who met the criteria for dignity, had their dignity maintained related to facility staff waiting for permission to enter the resident's room. (Resident #52)</p> <p>Findings include:</p> <p>On 12/11/12 at 3:35 p.m., the door to Resident #52's room was closed. At that time, CNA #3 knocked on the resident's door and entered the room prior to the resident giving the CNA permission to enter.</p> <p>On 12/12/12 at 1:30 p.m., the resident was in her room seated in her recliner. BNA #2 knocked on the resident's door and entered the room as she was knocking, she did not wait for a response from the resident to enter. The BNA proceeded to grab a pair of gloves and walked out of the resident's room.</p>	F0241	<p>F241 It is the policy of Miller's Merry Manor Portage 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. Staff will knock on residents doors and await resident response/permission prior to entering. All residents in the facility have the potential to be affected by this deficient practice. An all staff in-service will be held on 1/7/13 to review "Resident Rights" with an emphasis on resident privacy and knocking on resident doors and awaiting permission prior to entering. The staff will be re-educated on the importance of sharing medical status or other resident personal privacy information in a private area to ensure confidentiality and privacy. Facility department heads participate in routine quality assurance/satisfaction calls to facilitate expression of any resident concerns. The team will be instructed to inquire about resident privacy/dignity at next QA call. Any concerns will be documented on a quality assurance log and addressed</p>	01/17/2013	

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	<p>On 12/17/12 at 9:38 a.m., BNA #2 was observed to knock on the resident's door and enter the room without permission.</p> <p>The record for Resident #52 was reviewed on 12/12/12 at 1:49 p.m.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/14/12, indicated the resident's BIMS (brief interview for mental status) score was 15, which indicated that she was alert and oriented to person, place, and time.</p> <p>Interview with the resident on 12/18/12 at 8:32 a.m., indicated that she wished staff would wait for permission to enter her room prior to coming in.</p> <p>Interview with CNA #2 on 12/18/12 at 8:38 a.m., indicated staff should knock on doors prior to entering the resident's room and wait for permission to enter.</p> <p>Interview with the Staff Development Coordinator on 12/18/12 at 9:15 a.m., indicated staff should knock on the resident's door prior to entering and wait for permission to enter.</p> <p>3.1-3(t)</p>		<p>immediately. The QA logs will be shared at the facility monthly quality assurance meeting. The administrator, nursing managers, and other department heads will participate in random walking rounds of units to observe that staff are not overheard discussing private resident information in non-private areas and that staff are knocking on resident doors and awaiting reponse from resident prior to entering rooms. The Social Services Director or other designee will be responsible to complete the qa tool titled "Quality of Life/Dignity Review" (Attachment C) to observe no less than 5 resident per evaluation period as follows: Tool will be completed daily for 1 week, then bi weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter. The tool will be used during all three shifts and at different times. Any concerns will be documented by the Social Services Director or designee and addressed immediately. Resident's will be able to express concerns at any time including the monthly resident council meeting. Any concerns will be documented by the Social Service Director or designee. Any concerns identified will be addressed immediately and recorded on a QA tracking log. Any issues documented on QA tracking log will be reviewed in the monthly QA meeting to monitor and</p>				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to provide the necessary treatment and services related to monitoring and assessing residents with non pressure related skin conditions regarding bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 8 residents who met the criteria for non pressure related skin conditions. (Resident #101)</p> <p>Findings include:</p> <p>On 12/11/12 at 1:52 p.m., Resident #101 was observed lying in bed. At that time, he was noted to have a small bruise on the inside of his right forearm. The bruise was dark blue in color.</p> <p>On 12/13/12 at 9:05 a.m., the resident was observed lying in bed. At that time, he was noted to have a small bruise on the inside of his right forearm. The bruise was dark blue in</p>	F0309	<p>It is the policy of Millers Merry Manor, Portage to ensure that the facility provides the necessary care and services to attain or maintain the highest practical physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #101's bruise to his right forearm was assessed at the time of discovery on 12/14/12 and measured 2.3cm x 1cm. The area was added to the resident's treatment administration record (TAR) to be monitored for 7 days per facility policy. This bruise has now resolved without further complication. All residents are at risk to affected by the deficient practice. All other residents received a head to toe assessment to ensure that there were no other residents that had a previously unidentified non-pressure related skin concern. Licensed nursing staff will receive education by the DON or designee by January 10, 2013 to include the accuracy, assessment, documentation and follow up of all non-pressure</p>	01/17/2013	

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	<p>color.</p> <p>On 12/14/12 at 10:00 a.m., the resident was observed lying in bed. At that time, RN #1 was observed performing a skin assessment. There was a red/bluish bruise observed to his right forearm. RN #1 indicated at that time, she was unaware of the bruised area. She further indicated when a bruise was first observed, nursing staff were supposed to measure and write the area on the treatment sheet. She indicated the bruise was to be monitored for one week and then followed with a head to toe skin assessment weekly after that.</p> <p>The record for Resident #101 was reviewed on 12/13/12 at 10:27 a.m. The resident was admitted to the facility on 8/28/12. The resident's diagnoses included, but were not limited to, senile dementia with depressive behaviors, mood disorder, anxiety state, high blood pressure, anemia, convulsions, and cerebrovascular disease.</p> <p>Review of the Treatment Administration Record (TAR) for the month of 12/12, indicated there was no documentation of the bruise, its size or the location.</p>		<p>related skin concerns. The DON or designee will complete a weekly random audit of 10% of all residents who have had a head to toe skin assessment completed in the past week. The quality assurance tool "Non pressure related skin concerns" (Attachment F ) will be used for the random audits on a schedule of weekly 4 wks, then 2x/monthly for a month, then monthly thereafter until compliance reaches 100% for 3 months. Any identified issues will be corrected immediately and then logged on the QA tracking log for review during the facility monthly quality assurance meeting.</p>		

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	<p>Review of Nursing Progress Notes dated 12/6/12, indicated an intravenous catheter (IV) was inserted into the resident's right anterior forearm. Further review of Nursing Progress Notes dated 12/8/12 at 1:58 p.m., indicated the resident's peripheral IV was discontinued to the right anterior forearm, due to the ordered IV fluids were administered and there was no further need for the IV. At that time, there was no assessment of the resident's right forearm. There was no documentation indicating a bruise had formed after the IV had been discontinued.</p> <p>Review of the Nursing weekly assessment dated 12/10/12, that was completed on the midnight shift, indicated there were no skin issues and/or bruises noted on the resident's body.</p> <p>Review of the current plan of care plan dated 12/12 indicated the resident had anemia and was at risk for skin breakdown related to impaired/decreased mobility and a recent stroke. The Nursing approaches were to do a skin assessment at least weekly and observe for changes in the resident's</p>			

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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 5909 LUTE RD PORTAGE, IN 46368
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	<p>skin daily during care.</p> <p>A Complete Blood Count (CBC) was completed on 12/10/12. The resident's Hemoglobin was 8.1 a low reading (normal 13-17.3).</p> <p>The bruise was measured by RN #1 on 12/14/12 at 10:30 a.m. The bruise to the resident's right forearm measured 2.3 centimeters (cm) by 1 cm.</p> <p>Interview with the Director of Nursing on 12/14/12 at 10:20 a.m., indicated that she had just interviewed the resident and he thinks the bruise was probably from his last fall on 12/12/12, however, the Director of Nursing was informed at that time, the bruise was observed on 12/11/12 at 1:52 p.m.</p> <p>Review of the current 9/11/12, Wound and Non Wound Assessment and Documentation policy provided by Director of Nursing, indicated all non wound skin alterations will be managed by the licensed staff nurses. Initial assessment and documentation will be completed on the Nursing New skin alteration assessment, or on a new admit on the Nursing-admission assessment, or if due to an occurrence on the nursing occurrence</p>			

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	initial assessment. The non wound area will be placed on the TAR with instructions to monitor at least daily until it was healed.  3.1-37(a)				

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the Pharmacist Consultant report was acted upon timely for 1 of 10 residents reviewed for unnecessary medications. (Resident #70)</p> <p>Findings include:</p> <p>The record for Resident #70 was reviewed on 12/14/12 at 12:49 p.m. The resident had diagnoses that included, but were not limited to, hypertension, chronic obstructive pulmonary disease and asthma.</p> <p>The form titled, "Consultant Pharmacist's Medication Regimen Review" dated 9/26/12, and completed by the Registered Pharmacist, was reviewed. It indicated, "Medication administration recommendation. This resident is receiving Asmanex (medication for the treatment of asthma) inhalation daily. Please ensure the resident</p>	F0428	<p>It is the policy of Miller's Merry Manor, Portage to ensure that each residents drug regimen is reviewed at least once a month by a licensed pharmacist. Resident #70: pharmacy recommendation was in place on MAR 11/1/12. All residents with a pharmacy recommendation may be affected by the deficient practice. The pharmacy consultant will continue to make monthly facility visits to complete drug regimen reviews. The DON or other designee will have exit conference with pharmacist and a copy of all recommendations will be obtained. The DON or other designee will distribute the recommendations into the physician folders for review and any nursing recommendations will be given to the pertinent unit manager/charge nurse for completion. (In the event of a problem requiring immediate attention by the prescriber the facility will promptly contact the physician and the prescribers response will be documented on</p>	01/17/2013	

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	<p>rinses their mouth after each use to prevent thrush (an infection of the oral cavity)."</p> <p>The form had a hand written response that indicated, "added into orders for October MAR (Medication Administration Record)."</p> <p>Review of the October 2012, MAR indicated the instruction to rinse the mouth after use was not added to the administration of Asmanex.</p> <p>Review of the November 2012, MAR, indicated the instruction to rinse after the use of Asmanex, was printed on the MAR. Staff had signed the MAR and indicated the resident's mouth was rinsed after the medication was administered.</p> <p>On 12/14/12 at 1:54 p.m., interview with the Medical Records Supervisor, indicated she added the instruction to the October 2012, Physician Order Sheet, but did not add it to the October 2012, MAR. She indicated the Pharmacist's recommendation, dated 9/26/12, to rinse after the medication Asmanex was administered, was not initiated until November 1, 2012. She indicated the recommendation was not acted upon timely, it should have been initiated</p>		<p>the consultant pharmacy review and in the EMR.) The medical records designee will be responsible to monitor for timely nursing and or prescriber response. All pharmacy recommendations will be reviewed and completed in a timely manner. (the recommendations will be addressed by the next pharmacy consultant drug regimen review). The charge nurses will document the response to the recommendations in the EMR and a copy of the completed recommendation will be placed forwarded to the medical records designee. The medical records designee will document completion of recommendations on audit tool and then file on resident chart. The Medical Records Designee or other designee will be responsible to "Pharmacy Recommendation Follow Up" (Attachment G) weekly x 2 months, then bi-monthly for 2 months, then monthly thereafter to ensure ongoing compliance. Any trends/issues will be corrected and logged on facility tracking log. The facility tracking logs will be reviewed during the monthly QA meeting to monitor for continued compliance.</p>		

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	on October 1, 2012.  3.1-25(j)				

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F0441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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 their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview, the facility failed to ensure</p>	F0441	<b>F-Tag 441 Infection Control:</b> It is the policy of Miller's Merry	01/17/2013			

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	<p>an outbreak of gastroenteritis was thoroughly investigated and preventative procedures initiated for 28 residents with symptoms of gastroenteritis, of the 56 residents that resided in the facility at the time of the outbreak.</p> <p>Findings include:</p> <p>Review of the 2012 Infection Control Log on 12/18/12 at 10:05 a.m., indicated there was an outbreak of gastrointestinal infections in the month of June 2012. The log indicated there were a total of 28 residents who had symptoms of a gastrointestinal infection, that included nausea, vomiting and diarrhea. The census for that month was 56 residents. The percentage of residents who exhibited gastrointestinal symptoms was 50%.</p> <p>The symptoms were first noted on 6/22/12 and continued through 6/26/12.</p> <p>Interview with the Director of Nursing on 12/18/12 at 12:05 p.m., indicated the outbreak was reported to the Indiana State Department of Health on 6/22/12.</p> <p>The form titled, "Facility Incident</p>		<p>Manor, Garrett to to maintain an infection control program that is designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility will thoroughly investigate and provide preventative procedures for facility outbreaks. The facility will report infectious outbreaks as identified by residents with similar symptoms affecting 25% or more of the resident census to the ISDH per policy. All residents are at risk to be affected by the deficient practice. An all staff in-service is scheduled on 1/7/13 and will review the facility specific policies for basic infection control and hand-washing. Charge nurses will be re-educated on the charting procedures for residents experiencing symptoms of infection. The infection assessment will be initiated with any new onset and continued a minimum of daily while resident is actively treated and/or symptomatic. The DON or other nurse manager is responsible to review the 24hour report and EMR shift reports daily to monitor that follow up and appropriate interventions are in place for any resident with symptoms of infection. The infection control coordinator or other designee will be alerted immediately if multiple residents are identified as having similar symptoms and residents will be confined to their rooms if</p>				

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	<p>Report Form" dated 6/22/12, was reviewed. It indicated: "Brief Description of Incident: 19% of facility residents have developed nausea, vomiting, and diarrhea. One entire unit is free of any GI (gastro-intestinal) symptoms and have received the same meals from dietary that other units have received (therefore this is not dietary related).</p> <p>The immediate action taken were: 1. Residents are being kept on their respective units. Meals and activities will be provided on the units until the unit is free of symptoms. 2. Dietary interventions have been initiated i.e., jello, 7 up, broth, Gatorade, etc available. 3. Staff has been re-educated on importance of handwashing to prevent further spread of infection. 4. Staff re-educated to monitor effected residents for indications of dehydration 5. Families and physicians have been notified of residents with illness.</p> <p>Preventative measures taken: Corporate dietitian and corporate Quality Assurance nurse notified of event. Visitors are being asked to refrain from visiting until symptoms resolved."</p>		<p>the unit has 25% or residents with active symptoms. The investigation process into the presumptive cause, the number of residents affected, and plan to reduce/prevent further transmission of infection will be implemented. All staff will be promptly notified of the symptoms, who is actively exhibiting symptoms, and the plan to prevent further occurrences. The 24hour report tool will serve as a communication tool to identify residents who are symptomatic. The charge nurse will be responsible to identify which residents, the number of residents affected will be monitored every shift by the facility charge nurses and if the percent equals or exceeds 25% of the total resident census the Infection Care Coordinator or other designee will be immediately notified. The facility will post signs internally to advise visitors that the facility is temporarily quarantened and residents will remain on perspective units in rooms until symptoms are resolved for a 24 hour period. The house physicians will be notified per specific residents and the medical director will be consulted as needed if the facility requires facility wide confinement. The Charge nurses are responsible to make routine walking rounds of unit during tour</p>		

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	<p>Interview with the Director of Nursing on 12/18/12 at 1:01 p.m., indicated the report was not sent to the Indiana State Department of Health. She indicated she thought the information was sent to Indiana State Department of Health by the Administrator and he thought the Director of Nursing had sent the report.</p> <p>Review of the June 2012 Infection Control Log on 12/18/12 at 10:05 a.m., indicated there was no evidence an investigation into the cause of the outbreak was completed. No laboratory samples were obtained. There was no evidence to support that staff was trained on infection procedures to prevent the spread of the outbreak.</p> <p>Interview with the Staff Development Nurse on 12/18/12 on 11:30 a.m., indicated there was no evidence that the handwashing education was completed in June 2012. Further interview with the Staff Development Nurse, indicated she had completed an inservice training for all nursing staff at the last meeting in November 2012 (before they left the meeting she had them wash their hands). She further indicated she had no written evidence the inservice was completed, the inservice form was not</p>		<p>of duty to monitor that staff are following universal precautions and if required resident specific isolation techniques. The DON or other designee will be responsible to complete the QA tool titled "Infection Control Review" 3x weekly for 6 weeks, then biweekly for 4 weeks, then weekly x4 weeks, and monthly thereafter to ensure ongoing compliance. Any identified issue will be acted upon promptly then documented on a facility quality assurance tracking tool. The tracking tool will be reviewed at the monthly quality assurance meeting to ensure ongoing compliance.</p>				

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	<p>in the inservice book nor could she find the documentation in her office.</p> <p>Review of the inservice book indicated the last handwashing education was completed on January 2012.</p> <p>Interview with the Nurse Consultant on 12/18/12 at 12:41 p.m., indicated the outbreak was not thoroughly investigated to identify the cause of the gastrointestinal symptoms.</p> <p>3.1-18(a)(1)(A)</p>				

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F0463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the call system was functioning for 1 of 40 resident call lights checked for function. (Resident #47)</p> <p>Findings include:</p> <p>On 12/12/12 at 8:25 a.m., the call light for Resident #47, in Room 102/Bed 1, was activated. The call light did not light up at the Nurses' Station or outside of the resident's room. There was no sound at the resident's room or at the Nurses' Station that indicated the call light was activated.</p> <p>On 12/12/12 at 9:14 a.m., the 100 Unit Charge Nurse was asked to activate the call light for Resident #47, in Room 102/Bed 1. She activated the call light and it did not light up outside of the room or at the Nurses' Station. There was no sound at the resident's room or at the Nurses' Station that indicated the call light was activated.</p>	F0463	<p>It is the policy of Miller's Merry Manor, Portage to ensure the nurses' station be equipped to receive resident calls through a communication system from resident rooms, and toilet and bathing facilities.- Resident # 47 12/12/12 at 8:45 a.m. the Maintenance Supervisor checked call light in bathroom and found that the call light in the bathroom was not completely off. Maintenance Supervisor also replaced the call light electrical box to be certain it was functioning properly. All residents are at risk to be affected by the deficient practice. An all staff in-service is scheduled for 1/7/13 to review the call light system, for all staff answering call lights to ensure that the call light is completely turned off when call light is answered, by the Administrator, DON or designee. The Maintenance Supervisor or designee will be responsible to complete the quality assurance tool titled " Maintenance Service Review " (Attachment H ) daily for one week then 3 x weekly for 4 weeks, then monthly thereafter to ensure ongoing compliance. Any identified issues will be</p>	01/17/2013	

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	<p>Interview with the 100 Unit Charge Nurse at that time, indicated the call light was not functioning.</p> <p>Interview on 12/17/12 at 2:25 p.m., with the Maintenance Supervisor, indicated he had investigated the problem with the call light on 12/12/12, he indicated the call light in the bathroom was not completely off and because of that, the call light in the resident's room did not function. He also indicated that he replaced the call light electrical box to be certain it was functioning properly.</p> <p>3.1-19(u)(1)</p>		<p>documented on quality assurance tracking log. Any issues recorded on the facility tracking log will be reviewed during the monthly Quality Assurance meeting to ensure ongoing compliance.</p>		

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F0465 SS=B	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interviews, the facility failed to ensure the residents' environment was clean and in good repair related to, marred and scratched furniture and door frames and walls, peeling and soiled bathroom floor tile and stained carpeting. This affected 2 of 12 rooms on the 100 Unit, 4 of 12 rooms on the 200 unit and 3 of 12 rooms on the 300 Unit. (100 Unit, 200 Unit and 300 Unit)</p> <p>Findings include:</p> <p>The following was observed during the Environmental Tour on 12/17/12 at 2:55 p.m., with the Maintenance Supervisor and the Housekeeping Supervisor:</p> <p>On the 100 Unit:</p> <p>a. In Room 106, there was a 4 inch stain on the carpet in front of Bed 1. 2 residents resided in the room.</p> <p>b. In Room 109, there was a black ring around the bottom of the toilet on the tile floor. 2 residents resided in</p>	F0465	<p>It is the policy of Miller's Merry Manor, Portage to ensure that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.- Resident Rooms 106 will have the carpet cleaned, 109 will have bathroom floor replaced, 202 will have the furniture refinished and the wall painted, 206 will have the furniture refinished, 210 will have bathroom floor replaced, 211 will have furniture refinished and will have the carpet cleaned, 303 bathroom wooden door frame will be painted, 309 bathroom wooden door frame will be painted, &amp; 311 will have the door frame to the bathroom repainted by January 17, 2013. All residents are at risk to be affected by the deficient practice. An all staff in-service is scheduled for 1/7/13 to review the facility maintenance request procedure. Staff will be educated that any time the staff recognizes the residents' environment unclean or not in good repair to complete a maintenance request form (Attachment I), giving one copy to Maintenance Supervisor, and one copy to Administrator. The Maintenance Supervisor will then complete the maintenance</p>	01/17/2013	

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	<p>the room.</p> <p>On the 200 Unit:</p> <p>a. In Room 202 by Bed 1, the wardrobe closet had chipped wood veneer on the bottom 2 drawers. There were mars on the wall next to the bed. 2 residents resided in the room.</p> <p>b. In Room 206, the legs on the stationary chair in the room had scratches and mars. 2 residents resided in the room.</p> <p>c. In Room 210, the linoleum floor tile in the bathroom was peeled away from the wall by the sink. 2 residents resided in the room.</p> <p>d. In Room 211, the veneer wood covering at the base of the bedside wardrobe for Bed 1 was chipped and in need of repair. There were eleven 2 inch stains observed on the carpet in the room by Bed 2. 2 resident resided in the room.</p> <p>On the 300 Unit:</p> <p>a. In Room 303, the bathroom wooden door frame had mars and scratches. 2 residents resided in the room.</p>		<p>request and return the completed maintenance request form to the Administrator. The maintenance request serves as a communication device utilized by all staff to deliver maintenance request to Maintenance Supervisor. The maintenance request forms are routinely reviewed by the Administrator or designee M-F. The Maintenance Supervisor or other designee will be responsible to complete the quality assurance tool titled "Quality Assessment General Observations" (Attachment J) daily for 1 week then 3 x weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter to ensure ongoing compliance. Any identified issues will be documented on quality assurance tracking log. Any issues recorded on the facility tracking log will be reviewed during the monthly Quality Assurance meeting to ensure ongoing compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/18/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5909 LUTE RD PORTAGE, IN 46368		
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	<p>b. In Room 309, the bathroom wooden door frame had scratches and mars. 2 residents resided in the room.</p> <p>c. In Room 311, the door frame to the bathroom was marred and scratched. 2 residents resided in the room.</p> <p>Interview with the Maintenance Supervisor and the Housekeeping Supervisor at the time of the tour, indicated all of the above areas were in need of repair and or cleaning.</p> <p>3.1-19(f)</p>				