

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2016
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00191676.</p> <p>Complaint IN00191676 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: January 28 and 29, 2016</p> <p>Facility number: 000398 Provider number: 155564 AIM number: 100291110</p> <p>Census bed type: SNF: 10 SNF/NF: 46 Total: 56</p> <p>Census payor type: Medicare: 13 Medicaid: 37 Other: 6 Total: 56</p> <p>Sample: 03</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>To whom it may concern, Please accept the following Plan of Correction as creditable allegation of compliance to the deficiencies cited at the Miller's Merry Manor of Mooresville during a survey conducted on January 28th &amp; 29th, 2016. Inservice of staff has been completed and QA tools in place as of 2/12/2016. We respectfully request that paper compliance will be granted. If you have any questions please do not hesitate to call me at 317-831-6272. Thank you, Lindsey Hart-Administrator</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0279 SS=D Bldg. 00	<p>Q.R. completed by 14466 on February 08, 2016.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to ensure a careplan was revised after a change in nutrition assessment for 1 of 4 residents reviewed accuracy of care plans. (Resident #C).</p>	F 0279	It is the policy of Miller's Merry Manor to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the residents' medical, nursing, mental and psychosocial needs that are	02/12/2016

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	<p>Findings include:</p> <p>Resident #C's clinical record was reviewed on 12/28/16 at 10:15 a.m. Diagnoses included, but were not limited to: paraplegia due to brain damage and dysphagia (inability or difficulty with swallowing).</p> <p>A care plan with no title, dated 12/24/15 with goals current through 03/13/16, indicated Resident #C was at a nutritional risk related to having an NPO (nothing by mouth) diet due to dysphagia.</p> <p>Observation in the dining room on 1/28/16 at 12:15 p.m., Resident #C was noted to be eating a pureed lunch with nectar thicken liquids.</p> <p>Review on 1/28/16 at 10:30 a.m., of Resident #C's 24 hour condition report dated 01/20/16, indicated on the 3:00 p.m. to 11:00 p.m. shift, diet was changed to pureed with nectar thick liquid.</p> <p>There were no progress notes noted in Resident #C's clinical record related to changes placed on the 24 hour report sheet related to the new nutrition order.</p> <p>Interview with DON on 1/29/16 at 11:00</p>		<p>identified in the comprehensive assessment process. Resident C's care plan was updated to reflect the current diet order and has since discharged home. A complete audit was conducted on all current residents to ensure all diet orders are accurate on the care plan. Previously the Dietary Manager was responsible for updating diet orders in the care plan. The RN Unit Manager currently updated the care plan with all Physician orders except those diet related. Beginning 2/12/16 the RN Unit Manager will update all diet orders in the care plan when changed by the physician. The Dietary Manager &amp; Unit Manager were educated on this system change 2/12/16 (attachment A). The corrective action will be monitored using QA Tool titled Care plan (attachment B). This will be completed by the DON or designee weekly for 4 weeks then monthly thereafter. Any issues identified will be corrected immediately and logged on a QA Summary log. The QA summary logs are reviewed in the facility monthly QA meeting to monitor ongoing compliance. Corrective action will be completed by 2/12/16.</p>	

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F 0309 SS=D Bldg. 00	<p>a.m., indicated a change in condition would have triggered a report to change the care plan.</p> <p>On 01/29/16 at 1:00 p.m., the facility's policy for care plan revisions was requested. By survey exit on 1/29/19 at 3:30 p.m., the Administrator had not provided.</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to implement neuro checks after a resident fall (Resident #B) and the facility failed to continue to assess change in skin condition (Resident #A) for 2 of 4 residents reviewed for changes in condition.</p>	F 0309	It is the policy of Miller's Merry Manor to ensure that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care. All Nurses were in-serviced on	02/12/2016	

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	<p>Findings include:</p> <p>1) Interview with Resident #B on 1/28/16 at 7:20 a.m., with their daughter (POA) present, Resident #B indicated they had a fell, falling on his bottom and hitting the left side of his head. Resident #B indicated he had informed the day nurse he hit his head. He had been very clear to report he hit his head.</p> <p>Resident #B's clinical record was reviewed on 01/28/16 at 8:00 a.m.</p> <p>On 1/28/16 at 8:00 a.m., Resident #B's clinical records were reviewed and diagnoses included, but not limited to: atrial fibrillation and diabetes (insulin dependent). Resident #B's indicated BIMS (brief initial mental status) dated 01/15/16, was 15 out of 15 (cognitively intact and interviewable). Resident #B has an order for Coumadin related to Resident #B's diagnoses of atrial fibrillation.</p> <p>The Nursing 2014 Drug Handbook, 34th edition, copyright 2014, indicated "...black box warning...warfarin (Coumadin) can cause major or fatal bleeding...."</p> <p>Review of Nurses Assessment dated 01/18/2016 at 07:00 (7:00 a.m.),</p>		<p>the policies titled Incident/Accident Report Procedure &amp; Form (Attachment C) and Neurological Assessment Procedure (Attachment D) on 2/5/16 and on the policy titled Wound &amp; Non-wound Assessment &amp; Documentation, specifically section 3-A (Attachment E) on 2/12/16. The corrective action will be monitored using QA Tool titled Neuro &amp; Skin (Attachment F). This will be completed by the DON or designee 5 days a week for 2 weeks then weekly for 4 weeks and monthly thereafter. Any issues identified will be corrected immediately and logged on a QA Summary log. The QA summary logs are reviewed in the facility monthly QA meeting to monitor ongoing compliance. Corrective action will be completed by 2/12/16</p> <p><b>IDR REQUEST BELOW:</b> Miller's Merry Manor of Mooresville is requesting a paper review IDR of F-309. Through this process we request that this tag be deleted completely. The facility did follow its policies and does not feel there was any deficient practice that occurred.</p> <p>Please see (attachment D), Neurological Assessment Procedure, section 2 A-B. Resident #B fall on 1/18/16 did not require neuro checks to be started as there was no suspected head injury and resident denied hitting his head at the time of the initial assessment. Please see statement given by</p>	

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	<p>indicated neuro checks (a brief neurological assessment to measure the level of consciousness, movement of all extremities, etc.) were begun on 01/19/16 on the 11:00 p.m. to 7:00 a.m. shift, with no time frame noted on the 24 hour report or any nursing progress notes from the time of the fall.</p> <p>Interview with LPN #2 on 1/28/16 at 8:35 a.m., indicated LPN #2 went into Resident #B's room, found Resident #B found on floor next to end of their bed, assessed Resident #B, who indicated to LPN #2 they had fallen, but Resident #B did not mention hitting their head.</p> <p>Review of care plan on 1/28/16 at 10:15 a.m., with an initiated date of 1/19/2016, indicated Resident #B had bruise to right buttock and to left ear.</p> <p>Interview with Administrator on 1/29/16 at 3:00 p.m., indicated LPN# 2 came to the administrator (no time frame given) and was worried about not having started neuro checks, so the administrator advised LPN# 2 to begin them.</p> <p>Interview with (QAC) Quality Assurance Coordinator on 1/29/16 at 3:05 p.m., indicated per facility policy, neuro checks were not required if resident indicated they did not hit their head.</p>		<p>nurse,(attachment G) . The initial assessment, (attachment H), does shows there was ahead to toe assessment completed and resident did state his bottom was sore,which is where the only injury was found when assessed. Resident #B has a BIMS of 15. (Attachment I), a follow-up assessment completed 1/19/16 indicated a change noted with his left eye found to be bloodshot and the nurse did begin neuro checks at that time, (Attachment J). Neuro checks were started 1/19/16 at 3a and continued through 1/26/16 with no abnormal findings. This demonstrates that the facility did follow it's Neurological Assessment Policy and did start Neurochecks at the first sign of a suspected head injury. Resident #B is on Coumadin and did have an elevated INR of 12.47 on 1/18/16, (attachment K).It would be reasonable to expect that with an INR of 12 if Resident #B did hit his head it would have bruised immediately as his buttock did. It is also reasonable to expect that a result of an elevated INR of 12 could be a ruptured blood vessel in the eye without hitting his head. Resident #A did have on-going assessment of skin condition a evidence by Weekly Assessments completed on 1/20/16 &amp; 1/25/16 , (attachment L) please see section 8 question 10 on both assessments showing proof of area being assessed. (Attachment M) is the</p>	

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	<p>The administrator on 01/29/2016 at 3:15 p.m., presented the policy "neurological assessment procedures," dated 03/11/09, and indicated the policy was the one currently being used by the facility. The policy indicated ".... PROCEDURE B ...if a fall is not witnessed, and is unable to accurately inform staff that they did not hit their head should begin begin neurological assessment."</p> <p>2). On 1/28/16 at 6:45 a.m., Resident #A's clinical record was reviewed. Diagnoses included, but were not limited to:failure to thrive, dementia with Lewy bodies, and dysphagia.</p> <p>Nursing notes dated 01/19/2016 at 03:48 (3:48 a.m.), indicated the evening nurse (LPN#3) made rounds upon arrival for the 3:00 p.m. to 11:00 p.m. shift. Resident #A's g-tube was patent and intact. When LPN #3 returned to Resident #A's room, LPN#3 noted the tube from the pump had become dislodged from the g-tube, causing stomach acid to drain onto Resident #A's skin, causing a large read area measuring 9.5 cm x 31 cm and 7 cm x 26 cm (centimeters). The physicians on-call was notified and LPN #3 was advised to place A&amp;D ointment on it. Interview with LPN#3 on 01/28/16 at 11:07 a.m.,</p>		<p>administration record of the treatment beingapplied which also indicates that a Licensed Nurse was assessing the skin on aregular basis. The facilities process is for non-wound skin altercation to befollowed by the licensed floor nurse by monitoring with the application of atreatment. If there is not a treatmentordered then the nurse would still monitor daily for complications. With a treatment being in place for Resident#A this is sufficient monitoring of healing or complications. Resident #A's non-wound skin altercationsnever encountered complications with healing for a need to have a newassessment with measurements, wound nurse involvement or the need for furtherphysician notification. The area hassince healed and the physician has discontinued the treatment. In conclusion we feel that no deficient practice occurred andboth resident's care was appropriate and their highest well being wasmaintained. We ask that you take thisinto consideration when reviewing this information and find it appropriate toremove this tag.</p>	

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	<p>indicated the above nursing notes were correct.</p> <p>Interview of LPN #4 (night shift nurse), on 1/29/16 at 9:45 a.m., indicated staff had received a physician telephone order to apply A&amp; D ointment to area until wound nurse could assess.</p> <p>Review of the MAR (medication administration record) dated January 2016, did not indicate the A &amp; D ointment was applied.</p> <p>A new clarification order dated 01/19/16, indicated calmoseptine (an ointment used to heal skin irritations) was to be placed on Resident #A's excoriation to their right side and right arm every shift. The MAR indicated the calmoseptine was started on 01/19/16 on the 7:00 a.m. to 3:00 p.m. shift, however there were no initial's for the 11:00 p.m. to 7:00 a.m., shift as to whether the medication was applied.</p> <p>Interview with the DON on 1/29/16 at 2:00 p.m., indicated the facility works out of a pixus system only and that there are no over the counter medications and/or ointments kept in the medication rooms. She indicated if it is after 7 :00 p.m., and it is an over the counter medication, the facility's pharmacy will call the order into</p>			

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	<p>a local 24 hour pharmacy and one of the staff can go pick it up.</p> <p>After the initial documentation dated 01/19/2016 at 0:48 (3:48 a.m.), there are no measurements to review.</p> <p>Interview with DON on 1/29/16 at 9:25 a.m., indicated as the wound nurse, she does not focus on any excoriations, rashes, etc., mainly pressure sores and surgical incisions. She indicated skin assessments are to be done on Mondays. Review of Resident #A's skin sheets dated 1/20/16 at 15:41 (3:41 p.m.), indicated Resident #A had red area to right side no s/s of infection or drainage noted. No wound measurements were documented.</p> <p>Observation of Resident #A's skin on 1/28/16 at 6:10 a.m., accompanied by RN#2, indicated Resident #A's right side had 2 excoriated areas with 2 blister - like areas noted with red areas around the 2 excoriations. Also noted was a red rash-like area on Resident #A's right elbow. RN # 2 indicated the area, "looked much better."</p> <p>This Federal tag relates to Complaint IN00191676.</p> <p>3.1-37(a)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2016

FORM APPROVED

OMB NO. 0938-0391

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