

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN 47246			
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 28, 29, 30, 31 and June 3, 2013</p> <p>Facility number: 000286 Provider number: 155579 AIM number: 100291000</p> <p>Survey team: Gordon Tyree RN, TC Diana Sidell RN Joan Laux RN Nicole Wright RN</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 1 Medicaid: 44 Other: 18 Total: 63</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 6/12/13 by Suzanne Williams, RN</p>	F000000					

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>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 families were notified in regard to change of condition and a physician's appointment, for 3 of 3 residents</p>	F000157	<p>PLAN OF CORRECTION F0157addendum: F-157 Clinical records were reviewed and reflect appropriate notifications were made. Change of conditions and appointments were reviewed</p>	06/30/2013	

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	<p>reviewed for notification. (Residents #61, 4, and 71)</p> <p>Findings include:</p> <p>1. Resident #61's record was reviewed on 5/31/13 at 10:23 a.m. The record indicated Resident #61 had diagnoses that included, but were not limited to, mild cognitive impairment, chronic obstructive asthma, osteoarthritis involving multiple sites, anxiety, depression, high blood pressure, congestive heart failure, and atrial fibrillation.</p> <p>Nurse's Progress Notes, dated 8/16/12 at 10:00 p.m., indicated: "Resident lying on floor on left side, call light, blanket throw, water jug, and urinal on floor by resident. Resident states hit head, feels no pain from incident, resident states trying to stand to [urinate] and 'fell.'" The Nurse's Progress Notes also indicated a head to toe assessment was completed, neuro checks were done and Resident #61 had abrasions on the left knee, left antecubital, top of scalp and the "responsible party [was] not notified at this time."</p> <p>There was no further documentation in the resident's record that indicated</p>		<p>and assured that physicians and families were notified through the use of new orders received and the scheduling of appointments. Change of conditions and appointments will be monitored 5 days a week by the DON or designee. This process will be monitored by the Quality Assurance Committee times 12 months; this will be an on-going process.</p> <p>To correct this deficiency the facility will ensure that physicians and families are notified of any changes of conditions and doctor appointments. Residents #61, #4, #3 and # 71 still reside in building. Families will be notified of any changes and appointments. All resident have the potential to be affected by this deficient practice. To prevent reoccurrence corrective action will be accomplished by: all Licensed nursing staff will be inserviced on the correct procedure for physician and family notification of changes of conditions and doctor appointments. The corrective action will be monitored by the DON or designee. By reviewing all changes of conditions and physician appointments to assure that family and physician has been notified. Using a QA tool this will be completed 5 days a week. If any are identified they will be corrected at that time. The results</p>		

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	<p>the responsible party was notified.</p> <p>On 6/3/13 at 2:42 p.m., the Director of Nursing (DON) said they could not find any documentation that the family was notified of the fall on 8/16/12.</p> <p>2. On 5-29-13 at 1:47 p.m., during an interview, the ADON (Assistant Director of Nursing) indicated Resident #4 had a fall on 5-27-13. She indicated the resident had said he had just rolled off of the bed. No injuries were sustained.</p> <p>On 6-3-13 at 11:00 a.m., during an interview, LPN #3 indicated the family notification of a fall should be found in the resident's progress notes in their record or on the incident report.</p> <p>Resident #4's record was reviewed on 6-3-13 at 11:10 a.m. The initial assessment of a fall occurrence for 5-27-13, indicated under the responsible party notification "Not done at this time. Day shift to notify." No further information was indicated related to the this resident's fall in the progress notes for 5-27-13 through 5-29-13.</p> <p>On 6-3-13 at 2:55 p.m., during an interview, the DON (Director of Nursing) indicated she did not have</p>		<p>will be reviewed by the QA Committee monthly any recommendations will be followed. The systemic changes will be completed on or before June 30, 2013</p>		

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	<p>any further information the family was notified related to the 5-27-13 fall.</p> <p>3. Resident #71's record was reviewed on 6/3/13 at 2:35 P.M. The record indicated Resident #71 had diagnoses that included, but were not limited to, debility, coronary atherosclerosis, high blood fats, high blood pressure, heart disease without heart failure, esophagitis, obesity, diabetes, vitamin D deficiency, and cataracts.</p> <p>A nurse's progress note, dated 5/6/13, indicated an appointment was made for 5/20/13, but no documentation was found that resident # 71's POA (power of attorney) was notified of the appointment.</p> <p>During an interview with the resident's daughter, on 6/3/13, at 2:30 PM, the daughter stated: "No one called the family about the appointment that was made on May 6, 2013. The staff usually calls me about changes in condition, or other problems, but they didn't about the appointment."</p> <p>During an interview on 6/3/13, at 2:45 PM, the DON indicated either the son or son-in-law took the resident to the doctor's appointment, and he knew about the appointment. The DON</p>			

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	<p>said the POA had indicated she had no information about this appointment.</p> <p>A policy and procedure for "Physician & Family Notification of Condition Changes", with an effective date of 3/1/03, was provided by the Director of Nurses on 6/3/13 at 3:30 p.m. The policy indicated, but was not limited to, "A. Purpose: 1. To keep the physician, resident and family appraised of all condition changes...D. Family notification: 1. Notify the resident and responsible party of any change in condition that may or may not warrant a change in the treatment plan."</p> <p>3.1-5(a)(3)</p>				

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review, and interview, the facility failed to ensure the positioning of 2 residents (Resident #44 and #46) at the assisted dining room table was maintained for optimal eating of the meal, for 2 of 20 residents requiring assistance with eating in the assisted dining room during 1 of 2 dining room observations.</p> <p>Findings include:</p> <p>On 5/31/13 from 12:07 p.m. to 12:45 p.m. during lunch in the assisted dining area, the following was observed:</p> <p>1. Resident #46 was observed sitting at nose level at the dining room table. LPN #1 was observed to hand Resident #46 a half a banana two different times, one half of a grilled cheese sandwich at least three different times, and placed her drink on her plate closer to the resident's reach. During an interview at this</p>	F000246	<p>PLAN OF CORRECTION F 0246 Addendum: F-246 All residents were assessed for proper body alignment in their wheelchairs and at table placement; necessary adjustments or changes were made. This will be on going to assure that the resident is at optimal level during meals; 5 days a week x 2 weeks; 3 days a week x 1 week; then weekly x 12 months. If the resident is found to not be sitting properly a referral to therapy will be made for assistance; as well as table changes, if the table height is not appropriate. Quality Assurance Committee will monitor for 12 months; this will be an on-going process. To correct this deficiency the facility will ensure all residents have correct, optimal positioning. Resident #46 is positioned at a lower table. Resident # 44 is no longer consuming meals at the table d/t decline in overall health. Potentially all residents have the potential to be affected by this deficient practice. To prevent reoccurrence corrective action will be accomplished by: Nursing will be</p>	06/30/2013

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	<p>same time, LPN #1 indicated the resident ate best with finger foods handed to her. She also indicated Resident #46 sitting low could be a problem as she is not able to see the food.</p> <p>Resident #46's record was reviewed on 6/3/13 at 10:07 a.m. The resident's Occupational Therapy Plan of Care, with onset date of 3/22/13, indicated patient exhibits poor and unsafe postural alignment in wheelchair with sacral sitting and bilateral lower extremities extended on floor with a goal date of 3/25/13. A long term goal indicated the patient will demonstrate good and safe upright posture in adapted seating system with bilateral lower extremity support.</p> <p>Resident #46's Occupational Therapist progress and discharge summary, dated 4/10/13, indicated patient will achieve good and safe postural alignment while seated in adapted wheelchair system utilizing a seat cushion, back support, and footrests. The goal was met and discontinued on 4/2/13. The goal for exhibiting good and safe upright posture in wheelchair with contour back and pressure relief cushion with feet on floor was met and discontinued on 4/2/13.</p>		<p>inserviced on the correct procedure for body alignment and positions;reassignment of table placement.The corrective action will be monitored bythe DON or designee, during meals 5 days a week x 2 weeks, 3 days a week x 1 week; then weekly times 3 months. Any residenthaving positioning issues will be referredto therapy.The results will be reviewed by the QA Committee monthly any recommendationswill be followed.The systemic changes will be completed on or before June 30, 2013</p>		

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	<p>2. At 12:14 p.m. Resident #44 was observed in his wheelchair and was placed at the assisted dining room table. As he was pushed up to the table, and was observed leaning to the right side and was sitting low in the wheelchair. His hips were not observed against the bend in the chair. LPN #1 was observed to begin feeding Resident #44 who began to cough after taking a drink. At this same time during an interview, LPN #1 indicated Resident #44 should be repositioned in a more upright position as he was sitting too low in his wheelchair now.</p> <p>Resident #44's record was reviewed on 6/3/13 at 10:00 a.m. The resident's Occupational Therapist's progress and discharge summary, dated 5/7/13, indicated the patient would achieve good and safe upright posturing while up in his wheelchair to utilize appropriate positioning techniques to maximize function and comfort.</p> <p>3.1-3(v)(1)</p>						

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F000279 SS=D	<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 record review and interview, the facility failed to ensure a resident had a care plan for code status. This affected 1 of 26 residents reviewed for care plan development. (Resident #76)</p> <p>Findings include:</p> <p>Resident # 76's closed record review was done on 5/30/13 at 1:06 p.m. The record indicated Resident #76 was admitted on 1/11/13, with diagnoses that included, but were not limited to: Alzheimer's disease,</p>	F000279	<p>PLAN OF CORRECTION F 0279 Addendum: F-279 All resident charts were reviewed and reflect code status and care planning. With each new admission or change of code status an order will be obtained and care planned. This will be monitored five days a week through change of condition audit by the DON or designee. Quality Assurance Committee will monitor for 12 months; this will be an on-going process. To correct this deficiency the facility will ensure that each resident has a care plan</p>	06/30/2013			

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	<p>hypothyroidism, osteoarthritis involving multiple sites, depressive disorder, hyperlipidemia, high blood pressure, and cerebral atherosclerosis.</p> <p>Physician's recapitulation orders, dated 2/2013, and signed by the physician on 2/8/13 as being the current orders, indicated an order for "DNR" (do not resuscitate).</p> <p>Nurse's progress notes dated 2/10/13, for 11:45 a.m., indicated: "Resident was being brought back from the dining room with complaint of not being able to breath. Met resident at central nurses station and began to check vitals. 152/110, O2 (oxygen) 95%. Resident continue(d) to complain that she was unable to breath and began thrashing in wheelchair. O2 began to drop to 85%and placed resident on nasal cannula at 2L (liters). Resident taken to her room and further assessment started. Called for second nurse to call on call doctor for (Resident #76's physician) at 12:00 noon and 911 for medic ambulance. During call resident O2 dropped to 64%, placed resident on non-rebreather and hooked to large O2 tank at 5L. Second nurse began paperwork to send out resident when resident</p>		<p>addressing their preference of code status. Resident # 76 no longer residesin facility. Code status preference will beobtained upon admission. The physicianwill be contacted with the desired codestatus for the order. The code status will be care planned by the Unit manager or designee.All residents have the potential to be affected by this deficient practice.To prevent reoccurrence corrective action willbe accomplished by: Nursing staff will be in serviced on the correct procedure and documentation practices regarding codestatus and care planning.The corrective action will be monitored by theDON or designee. By reviewing all active charts in building. Each new resident will be monitored on admission.The results will be reviewed by the QA Committee monthly any recommendationswill be followed.The systemic changes will be completed on or before June 30, 2013</p>		

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	<p>stopped breathing. Called for help and second nurse return[ed] as I began CPR at 12:10 p.m. This nurse and second nurse continued CPR until [local town] city police arrived and joined in with CPR. At that time [local town] city officer hooked up AED to resident, no rhythm (sic) obtained, CPR continued. During CPR third nurse called family and notified them of condition. At approximately 12:30 p.m. [Local hospital] Ambulance arrived and took over the care of resident. [Local hospital] Paramedic called hospital and spoke with [physician]. It was decided at that time to call time of death at 12:56 p.m...."</p> <p>There was no care plan in the record that addressed the resident's code status.</p> <p>On 5/31/13 at 9:26 a.m., the Assistant Director of Nursing provided Resident #76's care plans that had been initiated on 1/13/2013, and there was no care plan for code status.</p> <p>During an interview on 6/3/13, at 3:03 p.m., the Minimum Data Set assessment (MDS) coordinator indicated; for some of the residents who are newer, they can edit the care plan, they have an option in the "care</p>						

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	<p>plan library" to put in the care plan for code status. The unit managers put in the care plan and the MDS coordinator looks over the care plan on day 8. She said they haven't been routinely putting in a care plan for code status.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review, observation and interview, the facility failed to ensure physician's orders were followed in regard to code status (Resident #76), and a resident's care plan was followed related to dietary supplementation if a resident ate less than 50% (Resident #23), for 2 of 23 residents reviewed for care plans/physician's orders.</p> <p>Finding include:</p> <p>1. Resident #76's closed record review was done on 5/30/13, at 1:06 p.m. The record indicated Resident #76 was admitted with diagnoses that included, but were not limited to: Alzheimer's disease, hypothyroidism, osteoarthritis involving multiple sites, depressive disorder, hyperlipidemia, high blood pressure, and cerebral atherosclerosis.</p> <p>Physician's recapitulation orders, dated 2/2013, and signed by the physician on 2/8/13 as being the current orders, indicated an order for "DNR" (do not resuscitate).</p>	F000282	<p>PLAN OF CORRECTION F 0282</p> <p>Addendum: F-282 All resident charts were reviewed for code status and care planning of wishes; this will be monitored 5 days a week through change of condition audits. All residents that consume less than 50% of their meal will be offered a replacement. Nutritional supplement intake will be monitored separately that is consumed at meals. This practice will be monitored 5 days a week by the Unit Manager or designee. Quality Assurance Committee will monitor for 12 months; this will be an on-going process. To correct this deficiency the facility will ensure residents orders are followed: Resident #76 no longer resides in facility. Resident # 23 physician orders and care plan are being followed; the percentage of nutrition supplement/food intake is being monitored. Potentially all residents have the potential to be affected by this deficient practice. To prevent reoccurrence corrective action will be accomplished by: All nursing staff will be inserviced on new orders and obtaining consumption of nutritional supplement and documentation. The corrective</p>	06/30/2013			

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	<p>A "State of Indiana out of Hospital do not Resuscitate Declaration and Order" indicated: "...I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation (CPR procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain....." Resident #76's power of attorney signed the document on 1/11/13. The physician's signature was also documented on the page, and there was no date the physician signed the document.</p> <p>A facility document titled "Cardiopulmonary Resuscitation Status Form" indicated, but was not limited to, "Cardiopulmonary Resuscitation (C.P.R.) is a basic emergency procedure for life support, consisting of artificial respiration and manual external cardiac massage, to establish effective circulation and ventilation in order to prevent irreversible brain damage, resulting form the lack of oxygen to the brain...It should be understood that without C.P.R. being initiated, death will probably occur. We will do C.P.R.</p>		<p>action will be monitored by the Unit Manager or designee. Orders will be collected 5 days a week and assured they are transcribed to appropriate tool/consumption of nutritional supplements will be monitored. The results will be reviewed by the QA Committee monthly any recommendations will be followed. The systemic changes will be completed on or before June 30, 2013</p>		

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	<p>unless you, the resident, and the physician have stated otherwise...."</p> <p>The box marked "C.P.R. will not be initiated" was filled in with an 'X', and Resident #76's power of attorney's signature was on the line marked "Resident/Responsible Party" with a signed date of 1/11/13 written beside the signature.</p> <p>Nurse's progress notes dated 2/10/13, for 11:45 a.m., indicated: "Resident was being brought back from the dining room with complaint of not being able to breath. Met resident at central nurses station and began to check vitals. 152/110, O2 (oxygen) 95%. Resident continue(d) to complain that she was unable to breath and began thrashing in wheelchair. O2 began to drop to 85%and placed resident on nasal cannula at 2L (liters). Resident taken to her room and further assessment started. Called for second nurse to call on call doctor for (Resident #76's physician) at 12:00 noon and 911 for medic ambulance. During call resident O2 dropped to 64%, placed resident on non-rebreather and hooked to large O2 tank at 5L (liters). Second nurse began paperwork to send out resident when resident stopped breathing. Called for help and second nurse return[ed] as I</p>			

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	<p>began CPR at 12:10 p.m. This nurse and second nurse continued CPR until [local town] city police arrived and joined in with CPR. At that time [local town] city officer hooked up AED to resident, no rhythm (sic) obtained, CPR continued. During CPR third nurse called family and notified them of condition. At approximately 12:30 p.m. [Local hospital] Ambulance arrived and took over the care of resident. [Local hospital] Paramedic called hospital and spoke with [physician]. It was decided at that time to call time of death at 12:56 p.m. Resident cleaned and family spent time with the body. Family request that the body be sent to [local] funeral home, order obtained. Body released at 2:30 p.m. to [local funeral home]. Family stated that they would return on Monday to pick up any remaining items."</p> <p>During an interview, on 6/3/13 at 9:27 a.m., RN #7 indicated: "The CPR did not have a Dr. signature yet, and their policy states if there is no Dr. signature, they initiate CPR."</p> <p>A policy and procedure for "New Orders - Verbal/Telephone", with an effective date of 7/14/2008, was provided by the Assistant Director of</p>			

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	<p>Nursing on 5/31/13 at 9:26 a.m. The policy indicated, but was not limited to, "1. Purpose: A. To ensure physician orders are transcribed correctly and carried out per plan. 2. Procedure: A. Telephone or Verbal Orders: I. Transcribe new orders on physicians T/O order form. If order is received after physician has made rounds and signed rewrites, a new Telephone order form must be used...IX. Make note on 24 hour condition report so new order is passed on in report. X. Adjust Health Care Plan accordingly."</p> <p>2. On 5/31/13 during lunch observation, CNA #1 was observed to offer Resident #23 her house shake. The resident was observed to only consume 25% of this nutritional supplement.</p> <p>Resident #23's record was reviewed on 5/30/13. The resident's weights were as follows:</p> <p>3/07/13: 134 pounds. 4/29/12: 122 pounds. 5/28/13: 121 pounds.</p> <p>The resident's care plan, dated 5/31/13, indicated the resident was a nutritional risk related to difficulty feeding self, and at risk for malnutrition. The goal was indicated</p>						

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	<p>to be free from significant weight loss. The interventions included, but were not limited to, serve regular diet as ordered, offer replacement for foods uneaten or less than 50% of meal, and serve four ounces house supplement at all three meals.</p> <p>The resident's food and fluid Intake form, dated from 5/19/13 to 6/3/13, indicated no information related to the heading "Supplements" for 4 meals where the resident had not eaten 50% of her meal. The nutritional supplement intake was not specified separately from the resident's fluid intake for the same time period.</p> <p>On 6/3/13 at 1:30 p.m. during an interview, LPN #1 indicated the amount of a meal/nutritional supplement served with a meal is not specified on the Food and Fluid Intake forms. The form only indicates whether the resident had accepted or declined the supplement.</p> <p>3.1-35(g)(2)</p>				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on record review and observation, the facility failed to ensure a resident who was totally dependent on staff for oral care, received necessary services to maintain good oral hygiene. This affected 1 of 1 resident reviewed for oral hygiene. (Resident #61)</p> <p>Findings include:</p> <p>Resident #61's record was reviewed on 5/31/13 at 10:23 a.m. The record indicated Resident #61 had diagnoses that included, but were not limited to, mild cognitive impairment, chronic obstructive asthma, osteoarthritis involving multiple sites, anxiety, depression, high blood pressure, congestive heart failure, and atrial fibrillation.</p> <p>A Quarterly Minimum Data Set Assessment, dated 4/1/13, indicated Resident #61 had modified independence, some difficulty in new situations only in cognitive skills for daily decision making, and was totally</p>	F000312	<p>PLAN OF CORRECTION F 0312Addendum: F-312 All dependent residents have had oral care. Five random residents will continue to be checked daily for oral care; 5 days a week times 2 weeks; 3 days a week times 1 week; then weekly times 12 months. Resident will continue to be checked to assure they are receiving oral care. Quality Assurance Committee will monitor for 12 months; this will be an on-going process. To correct this deficiency the facility will ensure residents have oral care. Resident # 61 continues to reside at the facility and will be assisted with oral care. Potentially all residents have the potential to be affected by this deficient practice. To prevent reoccurrence corrective action will be accomplished by: Nursing will be in serviced on the correct procedure for oral care The corrective action will be monitored by the Unit Manager or designee. Oral care will be checked on five residents on a random schedule; 5 days a week times 2 weeks; 3 days a week</p>	06/30/2013	

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	<p>dependent on one person's physical assistance for personal hygiene, which included brushing his teeth.</p> <p>A current care plan, dated 4/1/13, indicated Resident #61: "Needs extensive assist[ance] w/adls (with activities of daily living) due to: Weakness, mild cognitive impairment. Goal: Will have needs met/anticipated as evident by clean, well groomed appearance. Interventions/Tasks: Encourage to participate in ADL's as much as possible. ADL-Left side weakness... ADL-Oral care bid (twice a day)...."</p> <p>On 5/31/13, at 2:50 p.m., Resident #61 was observed sitting up in his wheel chair, outside of his room. His eyes were closed but he would speak when a family member spoke with him, and a white food-like substance was observed in his mouth, on the lower teeth.</p> <p>During an observation, on 6/3/13, at 3:23 p.m., with CNA #12 and CNA #13, Resident #61 was observed with white food particles in his teeth, on the cheek side of his mouth on the upper left side.</p> <p>3.1-38(a)(3)(C)</p>		<p>times 1 week; then weeklytimes 3 months. The results will be reviewed by the QA Committee monthly any recommendations will be followed. The systemic changes will be completed on or before June 30, 2013</p>		

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review, observation and interview, the facility failed to monitor dietary supplement consumption for 1 of 3 residents reviewed for significant weight loss of 4 residents who met the criteria for nutrition (Resident #23).</p> <p>Findings included:</p> <p>On 5/31/13 during lunch observation, CNA #1 was observed to offer Resident #23 her house shake. The resident was observed to only consume 25% of this nutritional supplement.</p> <p>Resident #23's record was reviewed on 5/30/13. Review of Minimum Data Set assessment, dated 3/12/13, indicated the resident was cognitively impaired and required extensive assistance with eating.</p>	F000325	<p>Plan of Correction F 0325Addendum:</p> <p>F-325 It has been determined that all 17 residents have received nutritional supplements per plan of care. Nutritional supplements during meals were counted in total fluids consumed. A separate tab was designated in the E- Mar for nutritional supplements consumed at meal time. This will be monitored 3 times per week x 4 weeks; and 1 time per week x 12 months. Quality Assurance Committee will monitor for 12 months; this will be an on-going process.</p> <p>To correct this deficiency the facility will properly monitor dietary supplement consumption. We will maintain each resident's nutrition status unless decline is unavoidable. The nutritional supplement intake will be specified separately from the resident's fluid intake for the same period. 17 residents and any additional residents for whom supplements are ordered could</p>	06/30/2013			

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	<p>The resident's weights were as follows:</p> <p>3/07/13: 134 pounds. 4/29/12: 122 pounds. 5/28/13: 121 pounds.</p> <p>The resident's care plan, dated 5/31/13, indicated the resident was a nutritional risk related to difficulty feeding self, and at risk for malnutrition. The goal was indicated to be free from significant weight loss. The interventions included, but were not limited to, serve regular diet as ordered, offer replacement for foods uneaten or less than 50% of meal.</p> <p>The resident's food and fluid Intake form, dated from 5/19/13 to 6/3/13, indicated no information related to the heading "Supplements" for 4 meals where the resident had not eaten 50% of her meal. The nutritional supplement intake was not specified separately from the resident's fluid intake for the same time period. The form indicated the resident declined supplements seven times.</p> <p>On 6/3/13 at 1:30 p.m. during an interview, LPN #1 indicated the amount of a meal/nutritional supplement served with a meal is not</p>		<p>potentially be affected by this deficient practice. To prevent recurrence corrective action will be accomplished by: Nursing staff will be inserviced on correct procedure and documentation practice in regard to food supplement intake. The corrective action will be monitored by the director of nurses or designee by a review of charting and observation three times per week times four weeks and once per week thereafter for a period of 3 months. The systemic changes will be completed on or before June 30, 2013</p>				

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	<p>specified on the Food and Fluid Intake forms. The form only indicates whether the resident had accepted or declined the supplement.</p> <p>3.1-46(a)(1)</p>			

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F000353 SS=D	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on record review and interview, the facility failed to provide sufficient staffing to meet the needs of the residents, related to waiting long periods of time for help. This affected 5 of 14 residents interviewed regarding staffing (Residents #77, 13, 71, 38, and 24), and had the potential to affect all 63 residents residing in the facility.</p> <p>Findings include:</p> <p>During an interview, on 5/28/13 at</p>	F000353	<p>PLAN OF CORRECTION F 0353Addendum:F-353 Staffing has been adjusted. Residents to receive showers as assigned; assigned showers will be followed up on per schedule. Call lights to be answered timely-call lights will be monitored throughout the day for timeliness with the QA tool. Unit Manager or designee will monitor. Quality Assurance Committee will monitor for 12 months; this will be an on-going process.To correct this deficiency thefacility will ensure the staff is meeting theneeds of residents.All residents have the potential to be</p>	06/30/2013

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	<p>2:34 p.m., Resident #77 indicated "They are always short of help, there is no time, sometimes, to do things at a different time if you don't feel like doing it when they ask."</p> <p>During an interview on 5/28/13 at 2:55 p.m., Resident #13 indicated they didn't have enough staff, and "in the daytime, showers didn't always get done and call lights take from 20 - 30 minutes to be answered."</p> <p>During an interview on 5/29/13 at 9:04 a.m., Resident #71 indicated they wait "forever" for help; they have to wait when getting up and when going to bed for help. They have waited up to an hour for assist after turning on their call light. First shift takes 10 minutes, 2nd shift up to an hour, and 3rd shift 5 minutes.</p> <p>During an interview on 5/29/13 at 9:46 a.m., Resident #38 indicated they are short of CNA's, and he waits a long time in the morning, before breakfast, then at night around 7 p.m. has to wait, and said he sometimes has to wait 30 to 45 minutes to get his call light answered.</p> <p>During an interview on 5/29/13 at 10:19 a.m., Resident #24 indicated she has to wait an hour sometimes to</p>		<p>affected by this deficient practice. To prevent reoccurrence corrective actions will be accomplished by: all Nursing Staffin servicing on showers and call lights. The corrective actions will be monitored by the Unit Manager or designee. Timing of call lights throughout the day. Following up on assigned showers, using the QA tool. The results will be reviewed by the QA Committee monthly any recommendations will be followed. The systemic changes will be completed on or before June 30, 2013 IDR F353 SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS We respectfully request that F 353 be deleted from the survey of 6/03/2013. We will explain/demonstrate how the facility does meet the requirements for providing sufficient nursing services to attain or maintain the highest practical physical, mental, and psychosocial well being of each resident. The facility posts a daily staffing roster that shows the number of staff scheduled each shift. The roster then has the ACTUAL HOURS WORKED put on it the next business day. There was not any mention of this and the surveyors indicated this was sufficient and acceptable. The staffing hours and ratios are within the industries standard of practice. In addition to the regular staffing there is always a nurse</p>		

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	<p>go to the bathroom, one day she had a bowel movement in her pants because no one would answer her call light. Said they insist she wait for help and not go to the bathroom herself. She indicated it was no certain time of day: "its bad anytime."</p> <p>The Assistant Director of Nursing (ADON), was interviewed on 6/3/13 at 2:10 p.m., and indicated the manner in which she replaces call ins: "Calls everyone in the book no matter what shift they work."</p> <p>On 6/3/13, at 2:37 p.m., the ADON indicated they do not have a specific policy and procedure for staffing; "we staff to meet the needs of the residents."</p> <p>3.1-17(a)</p>		<p>on call to assist or come in to help in addition to the DON. The facility Quality Measures and actual assessments of the residents demonstrate that the residents are well cared for. There is rare skin alteration, no odors, no residents "yelling out", and few injuries from falls or other. The facility's most recent survey of May 2013 had staffing reviewed by surveyor and was found to be in compliance. The facility has even increased and rearranged the staffing patterns for even better performance since that time. There were not any families that were interviewed indicating insufficient staffing. The facility has also been doing a focused Quality Improvement on call light response and has documentation to show time of call lights, residents interviewed and this is satisfactory. The facility added supervisor or manager that stays until 7pm or later each weekday and daytime hours on the weekends to assist with meals, call lights and whatever is needed. This started in May of 2013. The Social Service Director has been going over resident call light response time in addition to asking for any concerns in the monthly resident council meeting. It is the belief of the facility staff that due to this being such a recent and much discussed topic many of the residents have these points in fore front of their minds. One of</p>		

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			<p>the residents cited is also the resident council president and will let others know of "issues" brought up in the past even if they are resolved. We feel any previous concerns have been resolved. Resident # 77 has a diagnosis of Dysphasia and is non-verbal but it is stated "during interview" he says....See below care plan showing the absence of speech and diagnosis. The facility conducted interview with resident using his most freq method of communication of "thumbs up" for yes and "thumbs down" for no. Questioned him if he felt his call light was answered in a reasonable length of time and if he felt his needs were met, he gave the "thumbs up" for response. This resident is in stable physical condition without skin alterations, falls or decline in ADL's.</p> <p>Allergies No Known Allergies D.O.B. 2/1/1940 Physician</p> <p>Facility (08)Hope-Millers Merry Manor (812) 546-4416 Print Date 6/21/2013 Resident Name Resident #77 Admission Date 2/1/2013 Location 1 112 - 2</p> <p>Last Care Plan Review Completed: 5/13/2013 Resident #77- Page 9 of 23</p> <p>Focus Goals Interventions Description Pos Freq/Resolved</p>		

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			<p>COMMUNICATION: Inability or difficulty communicating. Absent speech Date Initiated: 2/4/2013 Revision on: 2/6/2013</p> <ul style="list-style-type: none"> Resident will be able to make needs known daily. <p>Date Initiated: 2/6/2013 Target Date: 8/29/2013</p> <ul style="list-style-type: none"> Resident will use writing as a means of communicating <p>Date Initiated: 2/6/2013 Target Date: 8/29/2013</p> <ul style="list-style-type: none"> Resident will use non-verbal techniques (gestures) to supplement communication <p>Date Initiated: 2/6/2013 Target Date: 8/29/2013</p> <ul style="list-style-type: none"> Encourage non-verbal communication with resident <p>Date Initiated: 2/6/2013 NRSCNAADSSDS</p> <ul style="list-style-type: none"> Provide reassurance and patience when communicating with resident <p>Date Initiated: 2/6/2013 SSNRSADCNA</p> <ul style="list-style-type: none"> resident prefers to use dry erase board <p>Date Initiated: 2/6/2013 ADNRSSS</p> <ul style="list-style-type: none"> resident uses thumbs up for yes and thumbs down for no <p>Date Initiated: 2/9/2013 SSADNRS</p> <p>Allergies No Known Allergies D.O.B. 2/1/1940 Physician</p> <p>Facility (08)Hope-Millers Merry Manor (812) 546-4416 Print Date 6/21/2013 Resident Name Resident #77 Admission Date 2/1/2013 Location 1 112 - 2</p>		

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			<p>Last Care Plan Review Completed: 5/13/2013</p> <p>A resident #3 is listed on the 2567 and there is not a resident #3 on the "sample resident list" Resident #71 has been interviewed by Social Services since May 2013 regarding call light response as part of the Quality Assurance/Improvement process and as a follow up to resident council concerns prior to that. Resident has not voiced dissatisfaction with this since several changes were made by the facility to improve. Resident #71 has a long standing history of repetitive concerns even to point of interfering with other residents' care that is not her place to do so. See attached Social Service Note and care plan related to this. This resident is in stable condition without any negative outcomes.</p> <p>Social Service Assessment Note from 6.4.13 Resident is adjusted to placement and happy with room/roommate. Resident does not want to talk to psychologist and states she is not depressed or sad. Resident does not show any s/s of sadness or depression. Resident has repetitive concerns and even when concerns are addressed resident continues to repeat same problems and get other resident's to agree with her (when residents are not with her they state that things are good).</p> <p>Facility (08)Hope-Millers Merry Manor (812) 546-4416 Print</p>	

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			<p>Date 6/21/2013 Resident Name Resident # 71 Admission Date 6/1/2012 Location 1 306 - 2</p> <p>Last Care Plan Review Completed: 6/10/2013 resident #71- Page 23 of 24</p> <p>Focus Goals Interventions Description Pos Freq/Resolved Resident has repetitive concerns and even when concerns are addressed resident continues to repeat same problems and get other resident's to agree with her (when residents are not with her they state that things are good)Date Initiated: 6/11/2012Revision on: 5/6/2013 RESIDENT #71 • Resident will express that she is satisfied with her care and have reduced episodes of repetitive complaints. Date Initiated:5/6/2013Target Date: 9/8/2013 • Encourage family support/involvement.Date Initiated:6/11/2012 Revision on: 5/6/2013 NRSSS •Encourage resident to envolve self in scheduled activities that he/she may enjoy.Date Initiated:6/11/2012 Revision on: 5/6/2013 NRSSSAD •If unable to imediately address request give resident time frame for task to be comepleted. Date Initiated:6/11/2012 Revision on: 5/6/2013 NRS</p>	

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			<ul style="list-style-type: none"> •keep resident informed of follow up from her concerns. Date Initiated:5/6/2013 SSNRS •Praise resident for demonstrating consistent acceptable behavior.Date Initiated:5/6/2013 SSNRSAD •Praise resident's effortsDate Initiated:5/6/2013 SS •Reassure resident they are safe, and needs will be met. Date Initiated:6/11/2012 Revision on: 5/6/2013 NRSSS <p>Resident #38 recent Social Service discharge planning note documents that resident is "happy" with placement. The care plan addresses his impaired cognition and short term memory loss. See below The resident has been interviewed routinely as part of the Quality Improvement focus on call light response since May of 2013 and had not had any dissatisfaction. The resident's condition has improved/stabilized since admission.</p> <p>Facility (08)Hope-Millers Merry Manor (812) 546-4416 Print Date 6/21/2013 Resident Name Resident #38 Admission Date 1/15/2013 Location 1 305 - 2</p> <p>Last Care Plan Review Completed: 6/18/2013 Resident #38- Page 17 of 30</p> <p>Focus Goals Interventions Description Pos Freq/Resolved COGNITION: Resident has</p>		

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			<p>cognitive impairments related to: short term memory loss -cognition fluctuates Date Initiated: 6/21/2012 Revision on: 1/28/2013</p> <ul style="list-style-type: none"> Resident will make decision about choice or preference Date Initiated: 6/21/2012 Target Date: 8/29/2013 Provide reality orientation Date Initiated: 6/21/2012 NRSSADCNA Ensure staff explain procedures at initiation of each interaction with resident, and allow time to process Date Initiated: 6/21/2012 NRSCNASSAD Ensure access to clock/calendar Date Initiated: 6/21/2012 SSAD Establish daily routine with resident Date Initiated: 6/21/2012 CNANRSADSS Monitor labs as ordered by physician. Date Initiated: 6/21/2012 NRS Notify physician as needed. Date Initiated: 6/21/2012 NRS Observe and report changes in cognitive status Date Initiated: 6/21/2012 NRSCNAADSS Provide activities for mental stimulation. Date Initiated: 6/21/2012 AD SS to visit w/ly and PRN Date Initiated: 6/21/2012 SS <p>Allergies Iodine, Codeine, Biaxin, Zocor, Crestor, Vasotec, and NSAIDs secondary to CRF D.O.B. 12/2/1928 Physician Resident #38</p>		

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			<p>Facility (08)Hope-Millers Merry Manor (812) 546-4416</p> <p>Resident # 24 actually has a care plan saying she does not use the call when she should and is encouraged to do so. She has never voiced concern with "becoming incontinent because of call light response" See her care plan entry. The resident also has anxiety related to care and routine for which she even requires medication. See Care plan for this. This resident is stable, without any negative outcomes.</p> <p>Focus Goals Interventions</p> <p>Description Pos</p> <p>Freq/Resolved</p> <p>Resident does not ask for assistance when she needs it at times, then complains that staff does not help her. (pushing her down the hallway and for adls) dx anxiety Date Initiated: 5/3/2012 Revision on: 5/3/2012</p> <ul style="list-style-type: none"> Resident needs to push her call light for assistance and verbalize that her needs are being met. <p>Date Initiated:5/3/2012 Target Date: 8/29/2013</p> <ul style="list-style-type: none"> Ask resident if she needs assistance when propelling self down the hallway. Date Initiated:5/3/2012 NRSSS offer assistance to resident when coming down the hallway (push to activities of choice) Date Initiated:5/3/2012 ADNRSSS praise resident for efforts to push her call light Date Initiated:5/3/2012 SSNRS remind resident to push her call 		

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			<p>light when she wants to go somewhere. (staff will answer call light and take her to where she wants to go)Date Initiated:5/3/2012 Revision on: 6/4/2013 NRSSS</p> <p>Allergies Amoxicillin D.O.B. 5/26/1917 Physician Diagnosis DIABETES MELLITUS, PARKINSONS DISEASE, UNSPECIFIED TRANSIENT CEREBRAL ISCHEMIA, OTHER AND UNSPECIFIED HYPERLIPIDEMIA, HYPERTENSION NEC, GENERALIZED ANXIETY DISORDER, ESOPHAGEAL REFLUX, VERTIGO AS LATE... see last page for a complete listing of the resident's diagnoses Facility (08)Hope-Millers Merry Manor (812) 546-4416 Print Date 6/21/2013 Resident Name Resident #24 Admission Date 11/2/2006 Location 1 302 - 2</p> <p>BEHAVIOR: Resident displays mood issues as exhibited by: Excessive nervousness, Restlessness related to change, bath schedule or if response is not immediate -worries about her son "Bucky" Dx; anxiety <u>H</u></p> <ul style="list-style-type: none"> •Resident will have no adverse S/E from medication through next review <u>H</u> •Anxiety will not cause distress as exhibited by eating, attending 		

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			<p>activities, socializing with others. <u>H</u></p> <ul style="list-style-type: none"> •Administer psych medication as ordered.[NRS] <u>H</u> •Monitor medication side effects at least daily on psychotropic medication record.[NRS] <u>H</u> •Notify physician as needed. [NRS] <u>H</u> •Listen to concerns and follow-up on these promptly as needed. [NRS,SS] <u>H</u> •Provide support and encouragement PRN[NRS,SS,AD] <u>H</u> •SS to visit PRN[SS] <u>H</u> •Document mood behavior #1: Excessive nervousness, Restlessness related to change Interventions:[1] inform of any change to normal routine as soon as possible [2] diversional task ie; read her prayer book [3] encourage to talk with friends [4]offer reassurance,support and tic.5) call resident's son to talk to her if needed.[Behavioral staff] <u>H ?</u> <p>In conclusion we do NOT feel this is a fair citation and questions can be leading or the fact that call light response time has been a big focus the past couple of months and is in the fore front of residents' minds as a recent concern. The lack of care problems supports sufficient staffing. Resident will occasionally report being "short of staff" because they think it will get more help for the facility. Thank-you for</p>		

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			your consideration in this matter.	

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F000364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure the consistency of the drinks served at meals was prepared in the prescribed consistency for 2 of 2 residents observed in a sample of 7 residents receiving supplements during meal service. (Resident #44 and #66)</p> <p>Findings included:</p> <p>On 5/31/13 from 11:45 a.m. to 12:45 p.m. during lunch observation, the following was observed:</p> <p>LPN #1 was observed to give Resident #44 a drink from one of his cups. After a few coughs, she again offered him another drink from the same cup. As he began to cough again, she was observed to check the contents of the cup. She indicated the drink was not thickened as prescribed and sent it back to the kitchen. After checking his water, LPN #1 also sent it back to the kitchen as she indicated it was not</p>	F000364	<p>Plan of Correction F 0364Addendum:</p> <p>F-364 It has been determined that all 6 residents have received the appropriate thickened liquids. Dietary Manager or designee will monitor consistency of liquids daily for one week; three times per week times four weeks; then weekly times 12 months. The dietary staff was able to correctly do a return demonstration on proper thickening. Quality Assurance Committee will monitor for 12 months; this will be an on-going process.</p> <p>To correct this deficiency the facility will properly ensure the consistency of drinks served at meals are prepared at the prescribed consistency. 6 residents and any additional residents for whom thickened liquids are ordered could potentially be affected by this deficient practice. To prevent recurrence corrective action will be accomplished by: Dietary, therapy and nursing staff will be inserviced on correct procedure and recipe in regard to adding a thickener product for various types of beverages. Staff will</p>	06/30/2013			

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	<p>thick enough for his prescribed thickened liquids</p> <p>Next, LPN #1 was observed to also check Resident #66's drinking fluids, which resulted in sending 2 of the 3 fluids back. At this same time during an interview, LPN #1 indicated Resident #66 was to have honey thickened liquids and indicated the resident's fluids served with her meal were not of the right consistency.</p> <p>On 5/31/13 at 3:20 p.m., during an interview, the Dietary Manager indicated she was unaware Resident #66 and Resident #44's drinking fluids had to be sent back due to the wrong consistency.</p> <p>Review of the Diet Type Report, dated 6/3/13, indicated Resident #66 and #44 were both on honey thick liquids.</p> <p>Review of doctor orders on 6/3/13 at 1:00 p.m., for Residents #44 and #66, both dated 5/1/13, indicated Fluid Consistency: Honey Thick Liquids.</p> <p>The care plan reviewed for Resident #66, dated 4/24/13, indicated nutritional risk. Interventions included, but were not limited to: "Provide thickened liquids at meals and</p>		<p>follow proper procedure to mix the prescribed amount of liquid and thickener product to achieve the prescribed result. The corrective action will be monitored by the dietary manager or designee by a review of observation daily for one week, three times per week times four weeks and once per week thereafter for a period of 3 months. The systemic changes will be completed on or before June 30, 2013 IDR F0364 SS=D We respectfully request that F0364 be deleted from the survey of June 3 rd , 2013. The thickened liquids for residents' #44 and #66 were mixed correctly by the dietary staff. They follow the directions of the thickener. After further investigation by facility it was determined that the liquids were/are mixed properly without the involvement of the surveyor. The dietary staff was able to correctly do a return demonstration on proper thickening of liquids, specifically of honey consistency. Residents' #44 and #66 did not have any negative outcomes and continue on the same prescribed and per recommendation of the speech therapist. It is not abnormal for resident #44 to cough with any part of any meal or fluid intake due to his C.V.A. LPN # 1 was educated on consistencies of thickened liquids on 6/24/2013. She is able to correctly identify Honey, Nectar and Pudding</p>		

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	<p>between meals of honey consistency."</p> <p>The care plan reviewed for Resident #44, dated 4/25/13, indicated Nutritional risk. Interventions included, but were not limited to: "Provide resident with sippy cups at meals. Staff to Assist resident with meals as needed. Serve puree w (with) honey thick liquids diet as ordered."</p> <p>Review of Physician order, dated 4/25/13, indicated Speech therapy recommended a change to honey thick liquids at this time for Resident #66.</p> <p>3.1-21(a)(1) 3.1-21(a)(2)</p>		<p>thickened liquids. In conclusion this citation was NOT based on any fact or "probes", it was not investigated or followed up by the surveyor to determine if the consistency was correct or not. Residents' # 44 and #66 Physicians orders, care plan and dietary menu were all correct as was the liquids they were served. We did meet the regulation and most importantly provide quality care for these residents</p>		

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN 47246			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was served under sanitary conditions in the assisted dining room area, related to hand washing and disinfection of tables, for 7 of 33 residents who use the assisted dining room during 2 of 2 dining room observations. (Residents #44, 46, 61, 50, 66, 43, 23)</p> <p>Findings include: On 5/31/13 from 12:07 p.m. to 12:45 p.m. during lunch in the assisted dining room, the following was observed: LPN #1 was observed to remove the soiled dishes from the table, handwashed for twelve seconds and positioned Resident #44 at the area where the soiled dishes were removed. No disinfectant or change of table cloth was observed at this place setting. LPN #1 placed a cloth protector on Resident #44. She was then observed to hand Resident #46</p>	F000371	<p>Plan of Correction F 0371Addendum: F-371 Residents at the assist tables- no new residents will be added to the table until the table is completely clear of residents. The table will then be cleared, sanitized and hands will be washed at appropriate times. DON, Dietary Manager or designee will observe daily. Quality Assurance Committee will monitor for 12 months; this will be an on-going process. To correct this deficiency the facility will ensure that food is served under sanitary conditions in the assisted dining area related to disinfection of tables and handwashing. Facility will allow all residents at a given table to finish dining before the entire table is then cleared and sanitized. After sanitization has been completed another group of residents will arrive to dine. Hands will be washed according to the prescribed time and method as per regulation. 22 residents and any others assessed to need staff intervention to eat their food could potentially be affected by this</p>	06/30/2013			

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	<p>half a cheese sandwich, rubbed her nose with her right sleeve, and began to feed Resident #44. No further hand washing or hand sanitizer use was observed.</p> <p>The Director of Admissions was observed to remove soiled dishes, washed her hands for less than fifteen seconds, then removed an unidentified Resident from the Dining Room.</p> <p>The Dietary Manager was observed to change the table cloth without disinfecting the table. She then removed a soiled cloth protector and washed her hands for 10 seconds.</p> <p>Residents #61 and #50 were observed to be brought into the assisted dining room where soiled dishes were removed, but no disinfectant was observed being used. New tablecloths had been put at their place setting.</p> <p>Resident #66 was observed to be brought to the assisted dining room and put at a place setting area where the tablecloth had not been removed or the table disinfected. The Administrator was observed serving her meal on the soiled tablecloth.</p>		<p>deficient practice. To prevent recurrence corrective action will be accomplished by: All serving and nursing staff will be inserviced on correct procedure in regard to table serving and handwashing. The corrective action will be monitored by the director of nurses, dietary manager, or designee by a review of observation daily for one week, three times per week times four weeks and once per week thereafter for a period of 3 months. The systemic changes will be completed on or before June 30, 2013</p>	

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	<p>The Dietary Manager indicated, during interview on 5/31/13 at 3:20 p.m., disinfectant stored in kitchen for use on dining room tables. She indicated she was not aware the tables were not being disinfected. On 5-27-13 at 12:15 p.m., Resident #43 was observed to get up and leave the table after eating. After the soiled dishes were removed, no disinfection or change of table cloth was observed. Next, an unidentified staff member brought Resident #23 to this vacant place setting and served her meal, which she began to eat.</p> <p>3.1-21(i)(3)</p>				

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F000464 SS=E	<p>483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>Based on observation and interview, facility failed to ensure adequate space for seating of residents in the assisted dining room for 1 of 2 dining rooms observed. This affected 5 of 33 residents in the assisted dining room. Residents #50, #1, #83, #52, and #61.</p> <p>Findings include:</p> <p>On 5/31/13 from 12:07 p.m. to 12:45 p.m. during lunch in the assisted dining area, the following was observed:</p> <p>Resident #61 was observed to be removed from his table setting to allow Resident #30 to be removed from the dining room area. At the same time during an interview, RN #4 indicated she had to remove Resident #61 in order to get Resident #30 out of the dining area.</p> <p>At the same time, during interview, LPN #1 indicated there was not</p>	F000464	<p>Plan of Correction F 0464Addendum: F-464 All twenty-two resident were assessed for proper placement with changes made to meet the needs of the resident for meal consumption. Changes will continue to be made as the residents change. This will be monitored by the DON, Dietary Manager or designee by observation 3 times daily for one week, three times per week times four weeks and once per week thereafter for 12 months. Quality Assurance Committee will monitor for 12 months; this will be an on-going process To correct this deficiency the facility will allow sufficient space for dining for those residents requiring assistance at meals. 22 Residents and any other residents assessed to need hands on assistance to dine could potentially be affected by this deficient practice. To prevent recurrence corrective action will be accomplished by: Tables will be re-arranged to allow approach of assisted dining residents in wheelchairs to come forward at a</p>	06/30/2013			

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	<p>enough room for everyone at one seating, and the residents had to be maneuvered around the tables to bring them in and out of the dining room.</p> <p>During this observation Resident's #50, #1, #83, #52, and #61 were moved around the dining room to fit around the tables. Resident #50 required two residents to be moved out of the way in order to position him at the dining room table.</p> <p>On 5/31/13 at 3:20 p.m., during an interview, the Dietary Manager indicated they had purchased the circular tables 2 months ago and had been working on arranging the tables to decrease the time required to serve the meals.</p> <p>3.1-19(w) 3.1-19(cc)(4)</p>		<p>direct angle and be placed at a table. Nursing staff will be inserviced on correct procedure and timing to assist residents to the assistive designated tables. The tables for these residents will be completely empty and sanitized prior to another group of residents being assisted toward the dining room therefore alleviating the need to move residents as the path will be empty and clear. The corrective action will be monitored by the director of nurses, dietary manager, or designee by observation 3 times daily for one week, three times per week times four weeks and once per week thereafter for a period of 3 months. The systemic changes will be completed on or before June 30, 2013</p>		