

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155150	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2014
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 640 W ELLSWORTH ST COLUMBIA CITY, IN 46725
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 27, 28, 29, 30, 31, 2014</p> <p>Facility number: 000071 Provider number: 155150 AIM number: 100273140</p> <p>Survey team: Martha Saull, RN TC Julie Call, RN Sue Brooker, RD Virginia Terveer, RN (October 27, 28, 29, 2014)</p> <p>Census bed type: SNF: 3 SNF/NF: 46 Total: 49</p> <p>Census payor type: Medicare: 2 Medicaid: 37 Other: 10 Total: 49</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	We would respectfully ask for paper compliance for our Recertification and State Licensure Survey conducted October 27 - 31, 2014, based upon the facility's submitted Plan of Correction and supporting documentation. Thank you.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F000246 SS=D	<p>Quality review completed on November 5, 2014 by Randy Fry RN.</p> <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.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was provided adequate foot support for 1 of 1 residents reviewed for positioning. (Resident #40)</p> <p>Findings include:  On 10/29/14 at 1:30 p.m. the clinical record of Resident #40 was reviewed. Diagnoses included, but were not limited to, the following: muscle weakness, osteoporosis, scoliosis and peripheral vascular disease. The MDS (minimum</p>	F000246	<p>Miller's Merry Manor of Columbia City is respectfully requesting a written IDR for F-Tag 246. Specifically, we are respectfully requesting that the tag be deleted. The reason for the request is as follows:</p> <ol style="list-style-type: none"> <li>1.The facility believes that additional information available during the survey was not considered.</li> <li>2.It was not clearly communicated to the facility the basis for why the citation was being given.</li> <li>3.The facility has been successful in ensuring that Resident #40 is in a position of comfort and is maintaining the</li> </ol>	11/06/2014

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	<p>data set) Assessment dated 7/25/14 included, but was not limited to, the following: moderately impaired cognition; extensive assistance with bed mobility and transfer; extensive assist with locomotion on unit and one person physical assist for locomotion on unit and balance not steady, only able to stabilize with staff assistance.</p> <p>On 10/27/14 at 10:45 a.m. the resident was observed in her wheelchair (wc) in her room. The wc was observed to have two foot pedals in place with a padded "footboard" observed. The footboard, which extended the width of the two outer bars of the wheelchair foot pedals, was observed to have been placed in front of the bars on which the foot pedals were attached to the wheelchair. The footboard was positioned on the wc pedals in a perpendicular manner to the foot pedals. Due to the placement of the footboard, the allowable space for the resident to place her feet on the bilateral foot pedals, was reduced to 1/2 the depth of the foot pedals, which resulted in a surface area of 2 inches for the resident to place her feet on. The resident had tennis shoes on and both feet were observed to be dangling freely, with no support provided by the attached foot pedals. The tips of both of the resident's feet were pointing in a downward direction.</p>		<p>functional Range of Motion (ROM) of the resident's bilateral lower extremities, while also respecting the resident's right to refuse splinting, prolonged stretching, and a specialized lift chair thus respecting the resident's specific preferences.</p> <p>4.Policies and procedures, resident observation, and the use of licensed therapy staff were all utilized to determine that Resident #40's needs were met through specialized equipment and, again, also meeting the resident's preferences for personal comfort.</p> <p><b>F246 483.15(e)(1).</b> Extended foot supports with calf supports were ordered by the facility's therapy department for Resident #40's wheelchair on 11/5/14 and were received by the facility on 11/6/14 (Please see Attachment T-1, T-2, and T-3). They were placed on the wheelchair of Resident #40 on 11/6/14 by the facility's Maintenance Technician. The extended foot supports are ten (10) inches long, and are attached to the top of the existing foot pedals, providing full foot support. It also has individual calf supports. Both the foot supports and calf supports extend from the outer side of the left foot pedal across to the outer side of the right foot pedal. Please note that the resident continues to point her left foot in a downward position and will remove her left lower extremity</p>	

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	<p>On 10/28/14 at 9:30 a.m. the resident was observed in her wc with both feet loosely dangling in the wc.</p> <p>On 10/28/14 at 3:55 p.m. the Resident was observed in her room. She was sitting in her wc with the tips of her toes touching the distal edge of the foot pedals on her wc.</p> <p>On 10/29/14 at 9:09 a.m. the resident was observed in her wc in her room with both feet hanging unsupported. The resident was observed to have foot pedals on her wc but both feet did not touch them.</p> <p>On 10/29/14 at 11:50 a.m. the DON (Director of Nursing) provided current copies of the facility CNA (Certified Nursing Assistant) assignment sheets. This form indicated the resident was to have "w/c with foot buddy, and foot pedals."</p> <p>On 10/29/14 at 1:30 p.m. the resident was observed in her wc and both feet were observed to be dangling freely without support.</p> <p>On 10/30/14 at 8:50 a.m. the resident was observed to be sitting in her wc at the nurses station. Both of her feet were observed to be hanging freely. The tips of</p>		<p>from the calf support to cross her legs even though an appropriate area of foot support is provided. Per facility policy (Please see Attachment T-4-A and T-4-B), each resident's functional status is screened – at a minimum – quarterly by a licensed therapist. This enables the facility to ensure each individual resident is provided with the appropriate accommodations according to their preferences to ensure the highest functioning level while maintaining resident comfort. It will be the responsibility of the Director of Nursing, or designee, in conjunction with the facility's therapy department, to monitor each resident's functional status. Resident's functional status' will be discussed with therapy staff in the facility's weekly rehabilitation meeting so that these resident may be screened by the therapy department if appropriate (Please see Attachment T-5). This will ensure that any changes in a resident's functional status is responded to in a timely manner so that appropriate interventions including, but not limited to positioning devices, splinting, wheelchairs and/or specialty chairs can be put into place. The facility submits this information as credible allegations of compliance. 11/6/2014</p>				

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	<p>both her feet were pointing downward towards the floor.</p> <p>On 10/30/14 at 11:00 a.m. resident was again observed in her wc with both feet dangling from her wc. The resident's left foot had the tips of her tennis shoes, pointing downward towards the floor. The resident's left foot was dangling with the level of the side of the foot pedal at the level of the middle of the resident's foot.</p> <p>On 10/30/14 at 1:07 p.m. the resident was observed in her wc again with both feet dangling unsupported from her wc.</p> <p>On 10/30/14 at 2:05 p.m. the ADON (Assistant Director of Nursing) was interviewed. She indicated the purpose of the footboard, also referred to as a "foot buddy", was to prevent the resident from pulling her legs back beneath the seat of her wc. The footboard was attached to the bar in front of the heel side of the pedals so there was only approx a 2 inch ledge for the resident to place her feet. The ADON indicated the resident was able to stand to toilet and also the resident was able to pull up her feet by the ankle and was able to move her feet up. At the time, the ADON asked the resident to move both her feet up and she did it very minimally. The</p>			

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	<p>ADON indicated that usually restorative did develop the restorative plan of care. The ADON indicated "you don't want her feet to be dangling."</p> <p>On 10/31/14 at 8:08 a.m. the ADON was interviewed. She indicated the resident was able to move both her feet as she stood with assistance to pivot to toilet. She indicated the facility had now requested a therapy screen on the resident. She indicated the facility had removed the resident's "footboard" to her wc so now the resident could put her feet on the foot pedals of the wc. The ADON indicated the position of the footboard did prevent the resident from being able to rest her feet on the foot pedals of the wc.</p> <p>On 10/31/14 9:10 a.m. the resident was observed in her room in her wc. She was observed to have no footboard on her wheelchair and her feet were now resting on the foot pedals.</p> <p>On 10/31/14 at 10:53 a.m. the resident was observed in wc with a different footboard than previously observed. The current footboard had a covered board which extends behind her heels and lower legs as well as underneath both her feet.</p> <p>On 10/31/14 at 11:41 a.m. the DON</p>			

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F000282 SS=E	<p>provided a copy of the "Occupational Therapy Plan of Care" dated 10/31/14. The "Functional Deficit Other" portion of the plan of care included, but was not limited to, the following: "...she needs better LE (lower extremity) support for her feet to improve the fall/skin/contracture risk. Foot/calf board was put in place today with plans to extend her footplates to better support her ankles/feet as the footplates don't go out far enough to do so presently...Current Level of Function; Patient exhibits a lack of foot/ankle...support while in wheelchair utilizing footrests...Goal: patient will achieve adequate support of...ankles/feet while seated in reclining wheelchair utilizing adaptations to wheelchair/footplate extensions/calf/footboard to...enhance...joint alignment..."</p> <p>3.1-19(v)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>A. Based on observation, interview and record review the facility failed to follow physician orders for heel floats for 1 of 1 resident (Resident #45) and also failed to</p>	F000282	<b>F282 483.20(k)(3)(ii).</b> It is the policy of the facility to provide services for all residents to assure they receive and maintain the highest practicable quality of care by qualified and well trained	11/25/2014

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	<p>follow physician orders and care plans for full code blue wristbands for 4 of 4 Residents reviewed for code status. (Resident #45, Resident #13, Resident #74, Resident #5)</p> <p>B. Based on observation, interview and record review, the facility failed to follow the plan of care and physician orders to prevent falls for 1 of 3 residents reviewed for falls (Resident # 60). The facility further failed to ensure the plan of care for restorative range of motion services was followed for 1 of 1 resident's reviewed for range of motion. (Resident #40)</p> <p>Findings include:</p> <p>A. 1. Review of the clinical record for Resident #45 on 10/29/14 at 10:52 a.m., indicated the following: diagnoses included, but were not limited to, diabetes with peripheral circulation disorder, polyneuropathy in diabetes, chronic pain syndrome, muscle disorders, and morbid obesity.</p> <p>A physician's order for Resident #45, dated 7/3/13, indicated heel floats on at all times while in bed every shift.</p> <p>A Minimum Data Set (MDS) assessment for Resident #45, dated 9/26/14,</p>		<p>persons in accordance to the resident's physician orders and written plan of care. The plan of care is completed using a holistic approach by all members of the Interdisciplinary Team based on the resident's individual needs and medical diagnosis. The facility will provide staff education to all nursing staff on the importance of following physician orders and the plan of care on or before 11/25/14. The education will include, but not be limited to full code status, use of heel floats, and low beds. Full code status education will include the importance of the use of the resident wearing a blue band and checking for placement each shift. If it is found that the blue band has been removed it will be replaced immediately. The resident's code status is also present on the C.N.A. Assignment Sheets. As a preventative measure, the facility approached each full code status resident and provided education on the purpose of the blue band and verified all resident's had a blue band present. The resident's plan of care and C.N.A. Assignment sheet was checked to assure documentation present and correct. Staff education will also include the use of heel floats. All resident's utilizing heel floats per physician orders will have them in place and will be checked each shift to assure present. If the resident refuses to</p>	

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	<p>indicated she required extensive assistance with the physical assistance of 2 staff for bed mobility. The MDS also indicated she required extensive assistance with the physical assistance of 1 staff for dressing.</p> <p>During an observation on 10/27/14 at 1:41 p.m., Resident #45 was observed resting in her bed. She was observed to be wearing socks, but did not have heel floats on as ordered. Her heels were observed resting on the mattress of her bed.</p> <p>During an observation on 10/28/14 at 9:10 a.m., Resident #45 was observed resting in her bed. She was observed to be wearing socks, but did not have heel floats on as ordered. Her heels were observed resting on the mattress of her bed.</p> <p>During an observation on 10/29/14 at 11:05 a.m., Resident #45 was observed resting in her bed. She was observed to be wearing socks, but did not have heel floats on as ordered. Her heels were observed resting on the mattress of her bed.</p> <p>A Certified Nursing Assistant (CNA) assignment sheet for Resident #45, provided by the DON on 10/29/14 at</p>		<p>wear them, then the C.N.A. will report this to the nurse who will document this on the treatment record by circling their initials and documenting the reason for doing so on the back of the record. Also as a preventative measure, all resident's with a physician's order for heel floats were identified and checked for placement/use and correct documentation of use, as well as assuring it was in the plan of care and on the C.N.A. Assignment Sheet. Resident #45 had the use of heel floats added to the C.N.A. Assignment sheet (Please see Attachment A-1). The use of low beds and the importance of placing in the low position and monitoring the location of the bed controls will also be included in the education. All low beds have been checked and the bed controls attached to the bed frame with Velcro to be out of reach in an effort to prevent a future occurrence. All nursing staff will receive re-education with return demonstration of ROM exercises to decrease the risk of other resident's being affected. This will ensure staff are well educated and aware of the meaning of the different terminology as well as demonstrating the task correctly. This education will be held on or before 11/21/14. It will be the responsibility of the nurse on each shift to complete nurses rounds each shift using the form</p>	

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	<p>11:50 a.m., did not indicate she was to have heel floats on at all times when in bed.</p> <p>CNA #1 was interviewed on 10/29/14 at 1:45 p.m. During the interview she indicated the CNA assignment sheets described what care each resident required.</p> <p>During an observation on 10/29/14 at 1:48 p.m., Resident #45 was observed resting in her bed. She was observed to be wearing socks, but did not have heel floats on as ordered. Her heels were observed resting on the mattress to her bed and her heels were observed to be touching each other.</p> <p>During an observation on 10/30/14 at 1:45 p.m., Resident #45 was observed resting in her bed. She was observed to be wearing socks, but did not have heel floats on as ordered. Her heels were observed resting on the mattress of her bed.</p> <p>CNA #2 and CNA #3 were interviewed on 10/30/14 at 2:03 p.m. During the interview they indicated a heel float was a boot placed over the resident's foot to protect it. When queried, they indicated Resident #45 was to have her heels floated, but she often removed them.</p>		<p>titled Nurse Rounds (Please see Attachment A-2) and will check on the placement of low beds, heel floats and blue bands for full code status resident's for 2 weeks, then at least daily for 2 weeks, then at least weekly for 2 weeks, and at least monthly. The Director of Nursing, or other designee, will be responsible to monitor that this process is complete and will also complete the Nurse Rounds form (Please see Attachment A-2) at least once daily for 2 weeks, then weekly for 2 weeks, then monthly for 1 month, in addition to the nurse. Any areas of concern will be documented on the facilities Quality Assurance Summary Log (Please see Attachment A-3) and will be reviewed at least monthly in the facilities Quality Assurance Meeting to ensure on-going compliance. The facility's goal is to provide all resident's with the highest practicable quality of care by following physician orders and care plans by qualified and well trained staff based on individual needs and medical diagnosis. The facility submits this information as credible allegations of compliance. 11/25/14</p>				

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	<p>When requested to find the heel boot for Resident #45, CNA #2 located the protective boots in the bottom of her clothes cabinet.</p> <p>LPN #4 was interviewed on 10/31/14 at 8:55 a.m. During the interview she indicated when a resident refused a treatment, the nurse would draw a circle around her initials on the Treatment Administration Record (TAR) on that date which indicated the resident had refused. She also indicated the nurse would also write on the back of the TAR the resident refused the treatment.</p> <p>The TAR for Resident #45 for the months of August, 2014, September, 2014, and October, 2014, indicated staff initialed her heels were floated on each shift. The TAR did not indicate the boots had been refused.</p> <p>The DON was interviewed on 10/31/14 at 10:30 a.m. When queried she indicated the backs of the TARs for Resident #45 were not copied since there was nothing documented on the back.</p> <p>A facility care plan for Resident #45, with a review date of 8/14/14, indicated the problem area of resident resistive to care/treatment. Interventions to the problem included, but were not limited</p>			

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	<p>to, discuss with resident implications of not complying with care/treatment regime and if resident refuses, attempt to determine reason, resolve if able, and inform physician as needed.</p> <p>A physician's order for Resident #45, dated 7/3/13, indicated to check the placement of the full code blue wristband every shift. The order also indicated to replace as needed in the event that it is removed or worn from excessive wear.</p> <p>A facility care plan for Resident #45, with a review date of 8/14/14, indicated the problem are of code status. Interventions to the problem included, but were not limited to, blue code bracelet on at all time to indicated full code, and check placement each shift.</p> <p>During an observation on 10/27/14 at 1:41 p.m., Resident #45 was observed resting in her bed. She was not observed to be wearing a blue wristband to indicate a full code status.</p> <p>During an observation on 10/28/14 at 9:10 a.m., Resident #45 was observed resting in her bed. She was not observed to be wearing a blue wristband to indicate a full code status.</p> <p>During an observation on 10/29/14 at</p>			

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	<p>11:05 a.m., Resident #45 was observed resting in her bed. She was not observed to be wearing a blue wristband to indicate a full code status.</p> <p>During an observation on 10/29/14 at 1:48 p.m., Resident #45 was observed resting in her bed. She was not observed to be wearing a blue wristband to indicate a full code status.</p> <p>During an observation on 10/30/14 at 10:20 a.m., Resident #45 was observed attending an activity in the lower floor dining room. She was not observed to be wearing a blue wristband to indicate a full code status.</p> <p>During an observation on 10/30/14 at 1:45 p.m., Resident #45 was observed resting in her bed. She was not observed to be wearing a blue wristband to indicate a full code status.</p> <p>A.2. A physician's order for Resident #13, dated 1/31/13, indicated to check the placement of full code blue wristband every shift. The order also indicated to replace as needed in the event that it is removed or worn from excessive wear.</p> <p>A facility care plan for Resident #13, with a review date of 8/14/14, indicated the problem area of code status.</p>						

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	<p>Interventions to the problem included, but were not limited to, resident refuses to wear blue bracelet designating a full code status, and bracelet attached to walker with resident's permission.</p> <p>During an observation on 10/30/14 at 3:10 p.m., Resident #13 was observed resting in an easy chair in her room. The blue wristband to indicate a full code status was not observed to be attached to her walker and she was not observed to be wearing the blue wristband.</p> <p>During an observation on 10/31/14 at 8:50 a.m., Resident #13 was observed resting in an easy chair in her room. The blue wristband to indicate a full code status was not observed to be attached to her walker and she was not observed to be wearing the blue wristband.</p> <p>A.3. A physician's order for Resident #74, dated 7/25/14, indicted to check the placement of a full code blue wristband every shift. The order also indicted to replace as needed in the event that it is removed or worn from excessive wear.</p> <p>A facility care plan for Resident #74, with a start date of 7/25/14, indicated the problem area of code status. Interventions to the problem included, but were not limited to, blue code</p>			

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	<p>bracelet on at all times to indicate full code, and check placement each shift.</p> <p>During an observation on 10/30/14 at 3:18 p.m., Resident #74 was observed resting in his bed in his room. He was not observed to be wearing a blue wristband to indicate a full code status.</p> <p>During an observation on 10/31/14 at 8:52 a.m., Resident #74 was observed resting in his bed in his room. He was not observed to be wearing a blue wristband to indicate a full code status.</p> <p>A.4. A physician's order for Resident #5, dated 11/2/12, indicated to check the placement of a full code blue wristband every shift. The order also indicted to replace as needed in the event that it is removed or worn from excessive wear.</p> <p>A facility care plan for Resident #5, with a review date of 8/14/14, indicated the problem area of code status. Interventions to the problem included, but were not limited to, blue code bracelet on at all times to indicate full code, and check placement each shift.</p> <p>During an observation on 10/30/14 at 3:17 p.m., Resident #5 was observed resting in an easy chair in her room. She was not observed to be wearing a blue</p>			

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	<p>wristband to indicate a full code status.</p> <p>During an observation on 10/31/14 at 8:45 a.m., Resident #5 was observed resting in an easy chair in her room. She was not observed to be wearing a blue wristband to indicate a full code status.</p> <p>RN #5 was interviewed on 10/30/14 at 3:30 p.m. During the interview she indicated a solid blue stretch bracelet was applied to a resident's wrist to indicate a full code status. She also indicated if a resident removed the bracelet, it was placed on their walker or wheelchair.</p> <p>Resident #45 was interviewed on 10/31/14 at 12:02 p.m. During the interview she indicated staff had just placed a blue bracelet on her wrist a short while ago, but did not know why.</p> <p>Resident #5 was interviewed on 10/31/14 at 12:07 p.m. During the interview she indicated she had not had her blue wristband on all week, but a band was placed on her wrist by staff earlier in the morning.</p> <p>The Director of Nursing was interviewed on 10/31/14 at 12:21 p.m. During the interview she indicated physician orders were to be followed.</p>			

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	<p>A current facility policy "Code Status &amp; Advanced Directive Determination", dated 5/24/10 and provided by the Director of Nursing on 10/31/14 at 1:15 p.m., indicated "...If the decision is to have CPR initiated, a navy blue wristband will be applied to the resident's wrist...In the even the bracelet is removed, it will be replaced immediately...."</p> <p>B.1. A review of the clinical record for Resident #60 on 10/29/14 at 11:00 a.m., indicated the following: diagnoses included, but were not limited to, dementia, diverticulosis of colon with hemorrhage, anemia, cardiomegaly, arteriosclerosis, emphysema, pulmonary collapse, olecranon bursitis, cardiac dysrhythmias, cerebral artery with infarct and difficulty walking.</p> <p>On 10/29/14 at 11:30 a.m., a review of the Minimum Data Set (MDS) assessment for Resident # 60, dated 5/30/14 and 8/30/14, indicated the following:</p> <p>-The Brief Interview for Mental status (BIMS) score was 02 which indicated Resident had severe impairment of cognition.</p> <p>-The Functional Status indicated the</p>			

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	<p>Resident required extensive assistance of 1 person for bed mobility, transfers, walking in room and locomotion on and off the unit. The Resident required extensive assistance with assistance of 2 persons for toilet use on 5/30/14 and extensive assistance with assistance of 1 person for toilet use on 8/30/14. The Resident's balance during transitions indicated he was not steady, only able to stabilize with human assist not limited to walking with Assistive device and moving from seated to standing position. The Resident also required use of mobility devices of a walker and wheelchair.</p> <p>A review of Resident #60's clinical records on 11/29/14 from 11:00 a.m. to 12:30 p.m., indicated the following:</p> <p>-A physician's order, dated 6/18/14, "...Low bed with floor mat in lowest position at all times...."</p> <p>-The Initial Occurrence Assessment, dated 4/14/14 at 22:45, indicated Resident #60 fell in his room. The nurse's documentation indicated the following, "...we heard the res (resident) yelling. The door was shut and when trying to open it realized the res was up against it...asked the res if he was ok and if he could move away from the door but</p>			

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	<p>did no [sic] answer...kept yelling. CNA went outside to res window and opened it to pull curtain to see that the res was sitting upright beside the door with his walker. Now aware of his position was able to open the door further to assess the res. Res was assessed while on floor. He had bruising on right arm and right side of back...." The Physician was notified and the Resident sent to ER for evaluation.</p> <p>-The Return for ER Visit Assessment dated 4/15/14 at 02:15 indicated, "...emergency treatment: X-ray....New orders received: Bacitracin et (and) DD (dry dressing) to skin tear RUE (right upper extremity) changed daily until healed....Daughter notified...."</p> <p>-The Weekly Nursing assessment, dated 4/16/14 at 14:26 (2:26 P.M.), indicated, "...Currently being treated for fracture/healing fracture...."</p> <p>-The Post Occurrence Assessment dated 4/18/14 at 15:24 indicated, "...date and time of occurrence: 04/14/14 at 10:45....Summary of occurrence: Res got up out of bed and ambulated with walker and fell in front of closet and door to room. Res found sitting with back against door...Type of injury: Bruising noted to right antecubital area, right side</p>			

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	<p>of back, right upper arm and ST (skin tear) in middle and to right forearm....Root cause: After HS (bedtime) care provided bed not placed in the low position....IDT recommendations: Will provide 1:1 education to aide who provided HS care and did not place bed down in the low position....Fall Risk Assess: ...confusion/forgetfulness...uses Assistive device for mobility...unsteady gait...impaired balance with transfers....Requires staff assist/supervision for ambulation...."</p> <p>-The Nursing Care Plan for Fall Risk indicated, "...characterized by risk factors: history of falls, confusion/dementia, unsteady gait, use of Assistive device...Date initiated 04/16/14 and revision on 10/15/14...Low bed w (with)/floor mat in lowest position all times..."</p> <p>-The Hospital Emergency Department report, dated 4/14/14, indicated, "...diagnoses were broken rib and skin tear of upper arm without complications...."</p> <p>During an interview with the ADON on 10/30/14 at 3:00 p.m., she indicated the Resident had gotten the bed controls and raised the bed himself. She indicated the resident messed with the bed controls in</p>			

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	<p>the past. She indicated the bed controls were located towards the head of the bed. She indicated after the resident fell the bed was switched out for a bed with the controls at the foot of the bed, out of the resident's reach.</p> <p>During an interview with the DON on 10/30/14 at 3:40 p.m., she indicated the Resident's bed was found to be raised to waist high when he fell on 4/14/14.</p> <p>During an interview with the ADON on 10/31/14 at 10:30 a.m., she indicated the staff were generally aware the resident might mess with the bed control. She indicated the bed controls could not be locked. She indicated the bed controls were attached to the back of the headboard with Velcro, out of resident's reach after he fell on 4/14/14 until the bed was changed out with the controls on the foot of the bed.</p> <p>During an interview the the DON on 10/31/14 at 11:30 a.m., she indicated the Resident could get out of bed when it was in the low position and the raised bed did not cause the fall. She indicated the recommendations were to change the bed so the Resident could not reach the bed control.</p> <p>During an interview with the ADON on</p>				

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	<p>10/31/14 at 1:25 p.m., she indicated there was no documentation on the Resident # 60's clinical record about him raising the bed with the bed controls. The ADON also indicated the care plan did not have an intervention to keep the bed controls out of resident's reach.</p> <p>A review of the Incident Investigation dated 4/14/14, provided by the ADON on 10/31/14 at 1:44 p.m., indicated, "...Staff error; not placing bed in low position...walker was within reach and should not have been in reach. Bed was in high position giving res. access to get out easily with walker...."</p> <p>A current facility policy "Fall Management Procedure", dated 08/28/2014, provided by the DON on 10/30/14 at 3:40 p.m., indicated, "...To assess all residents for risk factors that may contribute to falling and to provide planned interventions...Updated the plan of care each time there is a change in interventions and communicate it to staff...."</p> <p>A current facility policy "Care Plan Development and Review", dated 02/24/14, provided by the DON on 10/31/14 at 1:16 p.m., indicated, "...To assure that a comprehensive care plan for each resident includes measurable</p>			

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	<p>objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment process....The comprehensive care plan is designed to:...Reflect treatment goals and objectives in measurable outcomes....Show evidence that treatment or services provided are to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being...."</p> <p>B.2. On 10/29/14 at 1:30 p.m. the clinical record of Resident #40 was reviewed. Diagnoses included, but were not limited to, the following: muscle weakness, osteoporosis, scoliosis and CVA (Cerebrovascular accident). The MDS (minimum data set) Assessment dated 8/9/14 included, but was not limited to, the following: moderately impaired cognition; extensive assistance with bed mobility and transfer; extensive assist with locomotion on unit and one person physical assist for locomotion on unit and balance not steady, only able to stabilize with staff assistance; no impairment for functional limits in range of motion in the lower extremities. The MDS defined "lower extremities" as "hip, knee, ankle and foot."</p> <p>On 10/29/14 at 2:30 p.m. the plan of care</p>			

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	<p>for "Restorative Active Assisted Range of Motion Program (AAROM) for Resident #40 was reviewed. This plan of care had an initial date of 5/18/14 and a revision date of 10/22/14. This plan of care included but was not limited to, the following: "Risk for decline in functional range of motion related to: complications from prior hip fracture, debility, weakness. The goal was to perform 2 sets of 30 reps (repetitions) AAROM to...and lower extremities daily. Interventions included but were not limited to, the following: AAROM to lower extremity joints for 2 sets of 20 reps of AAROM exercises including abduction/adduction and flexion/extension while in sitting position.</p> <p>On 10/27/14 at 10:45 a.m. the resident was observed in her wheelchair (wc) in her room. The tips of both of the resident's feet were dangling and pointed in a downward direction, unsupported.</p> <p>On 10/28/14 at 9:30 a.m. the resident was observed in her wc with her both feet loosely dangling in the wc.</p> <p>On 10/29/14 at 9:09 a.m. the resident was observed in her wc in her room with both feet loosely hanging unsupported.</p>			

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	<p>On 10/30/14 at 8:50 a.m. the resident was observed to be sitting in her wc at the nurses station. Both of her feet were observed to be hanging freely. The tips of both her feet were pointing downward towards the floor.</p> <p>On 10/30/14 at 1:20 p.m. CNA #7 was interviewed. She indicated she had been trained as a Restorative CNA and provided such services to the residents. She indicated this resident did receive restorative services. She indicated this resident required her assistance to perform the range of motion activities. She indicated she had provided the resident's restorative program to the resident while the resident was waiting in the dining room for a group activity to perform earlier today. At the time, the resident's restorative plan of care was reviewed with CNA #7. The CNA was interviewed regarding what range of motion techniques she assisted the resident to perform. She indicated she moves the resident's ankles and her feet. She indicated they "roll" the ankles. When she was interviewed regarding what "adduction" and "abduction" meant, she indicated "I'll need to check on that."</p> <p>On 10/30/14 at 2:05 p.m. the ADON (Assistant Director of Nursing) was interviewed. She indicated the resident</p>						

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	<p>was able to move both her feet. She indicated the resident was able to stand and pivot to the toilet with staff assistance.</p> <p>On 10/30/14 at 3:10 p.m. LPN #8 was interviewed. She indicated she at times worked as a CNA and was familiar with restorative procedures and protocol and she also performed these on the residents. She indicated regarding the range of motion to the residents hips, she performed these in bed by "turning" the resident "side to side." LPN #8 did not indicate she performed the abduction and/or adduction to the resident's lower extremities as was directed in the restorative plan of care.</p> <p>On 10/31/14 9:10 a.m. CNA #6 was interviewed. She indicated she was one of the CNAs working on the floor today and she had provided the resident's restorative program before. She indicated she performed 15 reps (repetitions) each of the resident exercises and she indicated she doesn't really do anything with the resident's hips for range of motion, but when they "move the resident 's legs up and down that would move the hip area."</p> <p>On 10/31/14 at 9:12 a.m. CNA #6 provided the resident's current restorative</p>			

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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 640 W ELLSWORTH ST COLUMBIA CITY, IN 46725
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(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
F000514 SS=D	<p>plan of care from the facility computer. This restorative plan included the following: "RNP (restorative nursing program) do every shift; AAROM (Active Assisted Range of Motion) Program to all upper and lower extremities, joints for 2 sets of 20 reps. include abduction/adduction and flexion and extension, while in sitting position."</p> <p>On 10/31/14 at 11:31 a.m. the DON (Director of Nursing) provided a copy of the policy and procedure for "Restorative Nursing Program Procedures." This form had a policy start date of "2004-09-01." The Purpose included, but was not limited to, the following: "To provide services which promote the highest level of functioning in activities of daily living..." The procedure included, but was not limited to, the following: "...Restorative nursing services include: Passive and active range of motion exercises; maintenance programs after formal therapy programs..."</p> <p>3.1-35(g)(2)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented;</p>			

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	<p>readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review the facility failed to maintain accurate documentation of heel floats on the Treatment Administration Record for 1 of 1 resident (Resident #45).</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #45 on 10/29/14 at 10:52 a.m., indicated the following: diagnoses included, but were not limited to, diabetes with peripheral circulation disorder, polyneuropathy in diabetes, chronic pain syndrome, muscle disorders, and morbid obesity.</p> <p>A physician's order for Resident #45, dated 7/3/13, indicated heel floats on at all times while in bed every shift.</p> <p>During an observation on 10/27/14 at 1:41 p.m., Resident #45 was observed resting in her bed. She was observed to be wearing socks, but did not have heel floats on as ordered. Her heels were observed resting on the mattress of her</p>	F000514	<p><b>F514 483.75(I)(1).</b> It is the policy of the facility to maintain clinical records on each resident in accordance with accepted professional standards of practice that are complete; accurately documented; readily accessible; and systemically organized. It is our goal for all records to contain sufficient information to identify the resident's assessments, plan of care and services provided, results of preadmission screening conducted by the State as well as progress notes.</p> <p>The facility will educate all nurses of the importance of accurate and complete records on or before 11/25/14. This training will include appropriate documentation for resident refusals of treatment, according to physician orders, by circling the shift when the refusal occurred (i.e 1st, 2nd, and/or 3rd) and documenting the refusal on the back of the treatment record.</p> <p>All resident's with physician orders for heel floats will be monitored every shift for 2 weeks,</p>	11/25/2014

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	<p>bed.</p> <p>During an observation on 10/28/14 at 9:10 a.m., Resident #45 was observed resting in her bed. She was observed to be wearing socks, but did not have heel floats on as ordered. Her heels were observed resting on the mattress of her bed.</p> <p>During an observation on 10/29/14 at 11:05 a.m., Resident #45 was observed resting in her bed. She was observed to be wearing socks, but did not have heel floats on as ordered. Her heels were observed resting on the mattress of her bed.</p> <p>During an observation on 10/29/14 at 1:48 p.m., Resident #45 was observed resting in her bed. She was observed to be wearing socks, but did not have heel floats on as ordered. Her heels were observed resting on the mattress to her bed and her heels were observed to be touching each other.</p> <p>During an observation on 10/30/14 at 1:45 p.m., Resident #45 was observed resting in her bed. She was observed to be wearing socks, but did not have heel floats on as ordered. Her heels were observed resting on the mattress of her bed.</p>		<p>then at least daily for 2 weeks, then at least weekly for 2 weeks, and at least monthly by the nurse using the Nurse Rounds form (Attachment A-2). The Director of Nursing, or other designee, will be responsible for checking the treatment record audits daily for 1 week, then weekly for 3 weeks, then at least monthly. Any concerns will be addressed immediately and documented on a facility Quality Assurance Summary Log (Attachment A-3). The Quality Assurance Summary Logs are reviewed at least monthly through the facility's Quality Assurance Meeting to ensure on-going compliance.</p> <p>The facility's goal is to provide accurate, complete, accessible, organized and well maintained records according to professional standards of practice.</p> <p>The facility submits this information as credible allegations of compliance.</p> <p style="text-align: right;">11/25/</p>	
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	<p>CNA #2 and CNA #3 were interviewed on 10/30/14 at 2:03 p.m. During the interview they indicated a heel float was a boot placed over the resident's foot to protect it. When queried, they indicated Resident #45 was to have her heels floated, but she often removed them. When requested to find the heel boot for Resident #45, CNA #2 located the protective boots in the bottom of her clothes cabinet.</p> <p>LPN #4 was interviewed on 10/31/14 at 8:55 a.m. During the interview she indicated when a resident refused a treatment, the nurse would draw a circle around her initials on the Treatment Administration Record (TAR) on that date which indicated the resident had refused. She also indicated the nurse would also write on the back of the TAR the resident refused the treatment.</p> <p>The TAR for Resident #45 for the month October, 2014 indicated the following: on 10/27/14 , Resident #45's heels were floated while in bed each shift as ordered; on 10/28/14, Resident #45's heels were floated while in bed each shift as ordered; on 10/29/14, Resident #45's heels were floated while in bed each shift as ordered; and on 10/30/14, Resident #45's heels were floated while in bed each shift as</p>			

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	<p>ordered. The TAR did not indicate the boots had been refused.</p> <p>A current facility policy "Physician Order Transcription Procedure", dated 6/15/10 and provided by the Director of Nursing on 10/31/14 at 1:38 p.m., indicated "...Documentation on the administration records:...Circling an initial indicates that the procedure or med was not administered...If the procedure...is not given due to refusal...the initial is to be circled...turn to the back...page of the record and explanation is give (sic) as to why...not given...."</p> <p>3.1-50(a)(2)</p>				