

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 18,19, 20, 23, and 24, 2015</p> <p>Facility number: 000174 Provider number:155274 AIM number:100274810</p> <p>Survey team: Terri Walters, RN-TC Dorothy Watts, RN Sylvia Scales, RN Amy Wininger, RN 2/18, 2/19, 2/23, 2/24, 2015</p> <p>Census bed type: SNF: 4 SNF/NF: 53 Total: 57</p> <p>Census payor type: Medicare: 7 Medicaid: 42 Other: 8 Total: 57</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
F 0280 SS=D Bldg. 00	<p>Quality review completed on March 3, 2015 by Jodi Meyer, RN</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure care plans were revised, in that, a plan of care was not revised to include interventions to prevent the development of pressure area for a resident who experienced a significant change in condition for 1 of 3 residents who met the criteria for review of pressure areas. (Resident #16)</p> <p>Findings include:</p>	F 0280	<p>F280 Resident # 16 MDS history was noted to be incorrect on the 2567. 9-20-2013 entry MDS, 10-20-2013 discharge/return not anticipated MDS, 9-18-2014 entry MDS, 9-25-2014 admission MDS, 10-8-2014 discharge MDS (death). (Attachment A) Resident passed away 10-8-2014. All residents have the potential to be affected by this deficient</p>	03/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635		
(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	
	<p>The clinical record of Resident #16 was reviewed on 2/23/15 at 9:10 A.M. The record indicated the diagnoses of Resident #16 included, but were not limited to, Alzheimer's disease.</p> <p>The Admission Nursing Assessment dated 6/27/14 indicated Resident #16 experienced severe cognitive impairment, required the extensive assist of one staff for bed mobility, was at risk to develop pressure areas and/or experienced no areas of pressure.</p> <p>The Re-admission MDS (Minimum Data Set) assessment dated 9/25/14 indicated Resident #16 experienced severe cognitive impairment, required the extensive assistance of two staff for bed mobility, was at risk to develop pressure areas and/or experienced no areas of pressure.</p> <p>A Braden Scale risk assessment dated 9/20/14 at 9:00 P.M., indicated Resident #16 was at risk to develop pressure related skin impairment.</p> <p>A Nursing note dated 9/25/14 at 10:50 A.M. indicated, Resident #16 experienced a seizure.</p>		<p>practice. All health care plans will be reviewed to ensure risk factors are included in the health care plan. Systemic change all nurses were retrained on 3-6-2015 on how to initiate health care plans based upon risk factors so that they could initiate health care plans upon admission or within 24 hours. Admission health care plan reviews will be conducted within 7 days of admission and at this time the preliminary health care plan will be reviewed to ensure risks of the resident have been included (fall risk, skin risk, elopement risk, etc.) all findings will immediately be corrected and submitted to the monthly quality assurance committee for review. (Attachment B)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>The concurrent Nursing notes from 9/28/14 at 10:41 A.M. through 9/30/14 at 10:41 A.M. were reviewed and the following was noted:</p> <p>A Nursing note dated 9/28/14 at 10:41 A.M. indicated, "...Res [resident] currently sitting in w/c [wheel chair] at nurse station talking to self..."</p> <p>A Nursing note dated 9/28/14 at 1:37 P.M. indicated, "...resting in bed with eyes closed..."</p> <p>A Nursing note dated 9/29/14 at 9:38 A.M. indicated, "... remains in bed asleep..."</p> <p>A Nursing note dated 9/24/14 at 11:16 A.M. indicated, "...is still in bed asleep. Res noted to [sic] resting..."</p> <p>A Nursing note dated 9/30/14 at 10:35 A.M. indicated, "...remains in bed unresponsive...repositioned...has been unresponsive X [times] 2 days..."</p> <p>The Nursing notes from 9/28/14 at 10:41 A.M. through 9/30/14 at 10:35 A.M. lacked any documentation Resident #16 was repositioned and/or provided pressure relief to the heels, calves, and/or buttocks.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>A Care Plan for "Skin risk" dated 9/19/14 included the following interventions: "encourage meal/fluid intake, monitor labs as available, monitor skin daily during care, notify physician and family of any change in skin integrity, provide pressure reducing device to bed, serve diet as ordered, skin assessment at least weekly by nurse, skin assessment upon admission and then every shift for the first 3 days." The plan lacked any indication repositioning and/or pressure relief interventions had been implemented after Resident #16 experienced a significant change in condition on 9/28/14.</p> <p>A Nursing note dated 9/30/14 at 10:41 A.M. indicated, "...Noted a stage [sic] 2 pressure area measuring 5 cm [centimeters] X 4 cm to right heel et pressure area to left heel measuring 7.5 cm X 6 cm, both are fluid filled. Stage 2 pressure area to back of right calf measuring 1 cm X 1 cm, looks like a popped blister, surrounding tissue is red et blanchable. Stage 2 pressure area to right inner buttock measuring 4 cm X 4 cm, surrounding tissue is red et blanchable..."</p> <p>During an interview on 2/23/15 at 3:30 P.M., the DON (Director of Nursing) indicated the care plan for skin risk had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
F 0282 SS=D Bldg. 00	<p>not been revised after Resident #16 experienced a significant change in condition. The DON further indicated, at that time, the care plan should have been revised.</p> <p>The Policy and Procedure for Skin Management Program provided by the MDS nurse on 2/24/15 at 12:35 P.M. indicated, "...B. Care Plan Implementation: II. Interventions will be implemented according to the individual residents risk factors that will best reduce the risk of development of pressure...III. The plan of care will be updated with all changes to treatments or other interventions as they occur.</p> <p>3.1-35(d)(2)(b)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure the plan of care was implemented, in that, the facility failed to follow the physician's orders to notify the physician</p>	F 0282	F282 Services by Qualified Person/Per Care Plan: It is the policy of Miller's Merry Manor Rockport that all services provided or arranged by the facility will be provided by	03/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>of a weight gain for 1 of 1 resident reviewed for heart failure (Resident #63) and/or a dietary recommendation for a renal dietary supplement had not been initiated for 1 of 1 dialysis resident reviewed (Resident #28) . (Resident #28) (Resident #63)</p> <p>Findings include:</p> <p>1. On 2/19/14 at 9:54 A.M., Resident #63 was observed sitting in his wheelchair in his room with no distress noted.</p> <p>Resident # 63's clinical record was reviewed on 2/18/15 at 4:24 P.M. His diagnoses included but were not limited to, Parkinson's disease, chronic kidney disease, hypertension, and acute myocardial infarction.</p> <p>Physician's orders dated 1/1/15 included but were not limited to, "...HF (heart failure): Daily weight-after voiding and before brfst (breakfast)/meds (medications) with same clothes each day document weight in POC (plan of care) one time a day Notify MD of 2 lb gain in 1 day and 4 lb gain in 5 days..."</p> <p>A care plan problem of "HEART FAILURE: Congestive heart failure d/t (due to) recent MI (myocardial</p>		<p>qualified persons in accordance with each residents written plan of care. Resident #63 remains at the facility. The physician was notified of weight status. The resident continues on Heart Failure protocol. Resident #28 remains in facility. Physician was notified and order received for the renal supplement recommended. All residents have the potential to be affected. Review of all residents on the Heart Failure Protocol will be reviewed to ensure that weights are done as per plan of care and notification completed for weight changes. Dietary recommendations will be reviewed in the weekly Quality of Life meeting to ensure that these have been addressed with the physician. All nurses will be re-educated on the Heart Failure Protocol. (Attachment C) Dietary Manager was provided education on procedure to follow up on recommendations. To ensure this deficient practice does not recur the DON/Designee will complete the QA Audit Tools, Dietitian clinical report follow-up audit (attachment D) and Services per plan of Care QA tool (attachment E) weekly for the next 3 weeks, then monthly x3 and then quarterly thereafter. Issues identified will be addressed immediately with the staff and education/guidance provided. All issues will be documented on the QA Summary Log. The QA Summary Log will</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>infarction)" was initiated on 12/23/14. Interventions included but were not limited to, "...Daily weight in morning before brfst (breakfast) w (with)/same clothes on. Notify physician of 2/lb (pound)/day weight gain or 4 lbs (pounds) in 5 days..."</p> <p>On 2/20/15 at 12:45 P.M., facility documentation entitled, "Weights and Vitals Summary" was reviewed. Weights were reviewed from the dates of 12/24/14 to 2/19/14. On 1/18/15 a weight of 170.1 lbs was documented. The next day on 1/19/15 a weight of 173.2 lbs was documented which indicated a 3.1 lb weight gain. On 1/30/15 a weight of 163.1 was documented. The next day on 1/31/15 a weight of 168.7 lbs was documented, indicating a weight gain of 5.6 lbs in one day.</p> <p>A February weight of 167.1 lbs was documented on 2/18/15. The next day on 2/19/15 a weight of 171.4 lbs was recorded indicating a weight gain of 4.3 lbs in 1 day.</p> <p>On 2/20/15 at 12:49 P.M., the Director of Nursing (DON) was made aware of a 2 lb or more weight gain in 1 day on 1/19/15, 1/31/15, and on 2/19/15. Documentation was lacking of the physician being notified of a 2 lb weight gain in 1 day on</p>		be brought to QA monthly and reviewed and followed with the QA process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635			
(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			
	<p>the above days.</p> <p>On 2/24/15 at 8:47 A.M., the DON indicated documentation was lacking of physician notification of the 2 lb or more weight gain on 1/19/15, 1/31/15, and 2/19/15, as the physician had ordered.</p> <p>On 2/24/15 at 12:04 P.M., a facility policy entitled "Subject: Heart Failure Care Guidelines (policy start date 9/26/12) was reviewed. The policy included but was not limited to, "...2. Interventions...B. Daily weights using the same scales. Take after voiding and before breakfast. Physician notification for weight gain of 2 pounds in one day or 4 pounds in 5 days..."</p> <p>2. During an observation on 2/18/15 at 11:20 A.M., Resident #28 was sitting in her room in her recliner chair.</p> <p>Resident #28's clinical record was reviewed on 2/19/15 at 11:48 A.M. The record indicated Resident #28 was admitted to the facility on 9/16/14 and the diagnoses of Resident #28 included but were not limited to, renal dialysis status and acute respiratory failure.</p> <p>A care plan problem initiated 9/17/14, addressed Resident #28 as being nutritionally at risk related to a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>therapeutic diet. Interventions included but were not limited to, "... 1 can Nepro Daily for nutritional supplement daily Date initiated 02/04/2015..."</p> <p>A Registered Dietician (RD) progress note dated 2/3/15 at 2:43 P.M., indicated, "RD (Registered Dietician) assessment has been completed... Recommendation: Changes are recommended. Recommend Nepro (renal nutritional supplement) 1 can 1 daily for nutritional supplement d/t (due to) wt (weight) loss."</p> <p>On 2/23/15 at 10:35 A.M., the February Medication Administration Record (MAR) of Resident #28 and her physician orders were reviewed with LPN #14. Documentation was lacking in the MAR that the renal supplement, Nepro had been administered to Resident #28.</p> <p>On 2/23/14 at 1:13 P.M., during interview with the Director of Nursing (DON) she indicated the renal supplement /Nepro had been recommended by the dietician on 2/3/15. The DON at that time indicated Resident #28 should have been receiving the supplement Nepro.</p> <p>During interview with the DON on 2/24/15 at 8:45 A.M., the DON indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635		
(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	
F 0314 SS=G Bldg. 00	<p>the 2/3/15 dietary recommendation had been missed. She indicated LPN #14 had contacted the physician regarding the recommendation and a physician's order had been received for Nepro.</p> <p>On 2/23/14 at 3:15 P.M., a progress note dated 2/23/15 at 11:26 A.M., indicated, "Notified Dr. [physician's name] of dietary recommendation from 2/3/2015 for Nepro 1 can daily for wt [weight] loss. Order recd [received] to give as recommended."</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided, in that, two dependent residents admitted to the facility without areas of pressure developed pressure</p>	F 0314	<p>F314 Treatment/Services to Prevent/Heal Pressure Sores: Miller's Merry Manor Rockport respectfully requests to informally dispute this citation. It is the policy of Miller's Merry Manor, Rockport that a</p>	03/26/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635			
(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			
	<p>areas for 2 of 3 resident who met the criteria for review of pressure. (Resident #15, Resident #16) This deficient practice resulted in Resident #15 experiencing three deep tissue injuries to the right posterior calf.</p> <p>Findings include:</p> <p>1. During an interview on 2/18/15 at 11:49 A.M., indicated Resident #15 had experienced pressure wounds related to the use of an immobilizer after admission to the facility.</p> <p>During an observation on 2/19/15 at 11:50 A.M., Resident #15 was sitting in a wheelchair wearing an immobilizer splint which extended from the right thigh to the bottom of the right calf. The wheelchair's right leg rest was elevated and Resident #15's right, immobilized leg was rested on the leg rest in an upward position. There were no additional pressure relieving cushions on the leg rest at that time.</p> <p>On 2/19/15 at 11:50 A.M., Resident #15 was observed sitting in a wheel chair with an immobilizer right leg resting on the leg rest of the wheelchair. The immobilized right leg was observed, at that time, in direct contact with the leg rest with no pressure relief. During an</p>		<p>resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable: and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Resident # 16 is no longer in facility. Resident # 15 still resides in facility and no longer has pressure ulcers. All residents have the potential to be affected by this deficient practice. All residents reviewed to ensure those at risk for breakdown are identified and appropriate measures are in place to prevent skin breakdown. All residents are assessed upon admission for skin issues and risks for skin breakdown. The plan of care is then developed and is reflective of these assessments. The skin is assessed daily every shift for 3 days, then at least daily for 14 days, then no less than weekly thereafter. The physician and POA are notified of any changes noted in skin integrity. The care plan is updated accordingly with changes. The facility reeducated all nursing staff on 3/6/2015 regarding the policy for skin assessment, identifying risks and prevention of breakdown. To ensure that all residents identified as risk for breakdown have proper preventative</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635			
(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			
	<p>interview, at that time, Resident #15 indicated the immobilized right lower leg did not experience pressure relief in the bed or the chair.</p> <p>The clinical record of Resident #15 was reviewed on 2/23/15 at 9:30 A.M. The clinical record indicated Resident #15 was admitted to the facility on 1/20/15 without skin impairment and diagnoses including, but not limited to, closed fracture of the right femur.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 1/27/15 indicated Resident #15 was at risk for developing a pressure ulcer, experienced moderate cognitive impairment and needed the extensive assistance of 2 staff for bed mobility and transfers.</p> <p>A Physician's Order dated 1/20/15 indicated an order for, "...Immobilizer to right leg at all times..."</p> <p>The Nursing Admission Assessment dated 1/20/15 indicated Resident #15 had no skin impairments upon admission and had a leg immobilizer on her right leg for a fractured right femur.</p> <p>A Care Plan "...area to back of right leg; fluid filled blister..." dated 2/3/15 indicated, "...Remove immobilizer daily</p>		<p>measures in place upon admission the facility wound nurse will complete the QA Tool "Pressure Ulcer Risk/Reduction and Treatment Review" (attachment F) on all new admissions for the next 30 days, then on 10% of the resident population and all residents identified with pressure ulcers on a monthly basis thereafter. Any identified issues will be addressed immediately. Any concerns will be documented on the QA Summary Log. This will be followed and reviewed in QA monthly and any needed changes will be implemented by the QA Team. Informal Dispute for F-314 Resident #15 developed pressure related ulcers under a full leg immobilizer being worn at all times for treatment of a non-surgically repaired right femur fracture. Removal of the immobilizer for skin inspection and care was provided daily beginning at admission as per standard of practice and it was during one of these inspections the skin blister was observed. The facility acted promptly in notifying the physician and family and in applying a sheepskin inside the immobilizer extending the length of the back. The facility objects to the assertion that no pressure relief was provided as the sheepskin provided pressure relief and protection from the metal bar that extended the length of the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>and prn to inspect skin...sheep skin in immobilizer...no skin to skin contact..."</p> <p>The care plan lacked any documentation related to providing pressure relief to the immobilized right calf.</p> <p>Wound #1</p> <p>A "Nursing-New skin alteration assessment dated 2/2/15 at 6:12 P.M., indicated, Resident #15 experienced a blister on the right lower calf. The assessment lacked any documentation pressure relief was provided to the immobilized right leg.</p> <p>A Pressure Ulcer assessment dated 2/9/15 at 2:21 P.M., lacked any documentation pressure relief was provided to the immobilized right leg. The assessment indicated, "...C. Definitions...STAGE 2: ...May also present as an intact or open/ruptured serum (clear liquid-filled blister..."</p> <p>A Pressure Ulcer assessment dated 2/16/15 at 4:25 P.M., lacked any documentation pressure relief was provided to the immobilized right leg.</p> <p>A Pressure Ulcer assessment dated 2/18/15 at 4:50 P.M., lacked any documentation pressure relief was provided to the immobilized right leg.</p>		<p>immobilizer. This intervention provided pressure relief between the immobilizer itself and the skin. In addition, the facility floated the resident's heels from the time of admission which involved placing pillows under the immobilizer to raise the heels up off the bed. Resident had a pressure relieving mattress on the bed, cushion in her wheelchair and was turned and repositioned every 2 hours when in bed. (Attachments 1-4) When consulting with therapy, it was determined to not be a safe practice to place a pillow or padding under an immobilized leg while in a wheelchair as the pillow/padding could slip out of place causing injury to the area in which the immobilizer is attempting to protect or heal. As of March 9, 2015, all pressure areas beneath the immobilizer have healed without complications and are being treated prophylactically with skin prep and foam dressing. (attachment 5) Of importance is the fact all wounds have healed, thus the contention the lack of external pressure relief when up in her chair caused the development of these wounds is not accurate or factual.</p> <p>***** ***** ***** Resident #16 was originally admitted on 9/20/13 was discharged 10/1/13 and then re-admitted on 9/18/14. Unsure why 2567 indicates an admission</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635		
(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	
	<p>During an interview on 2/20/15 at 12:15 P.M., the Wound Care Nurse indicated Wound #1 was caused by the metal support in the leg immobilizer. The Wound Care Nurse then indicated Resident #15 experienced a second wound [Wound #2] located lateral to Wound #1 on 2/16/15.</p> <p>Wound #2</p> <p>A Pressure Ulcer assessment dated 2/16/15 at 4:15 P.M. indicated Resident #15 experience a purple Stage 2 blister below the bend of the right knee. The assessment lacked any documentation pressure relief was provided to the immobilized right leg. The assessment indicated, "...6. SUSPECTED DEEP TISSUE INJURY: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear..."</p> <p>A Care Plan for "Stage 2 fluid filled blister below bend..." dated 2/16/15 lacked any documentation pressure relief was provided to the immobilized right leg.</p> <p>During an observation on 2/23/15 at 2:16 P.M., the immobilized right leg of</p>		<p>assessment was completed on 6/27/14 as this resident was not a resident here at that time and no assessment exists for this resident for that date. She was readmitted from another long term care facility 9/18/14 with a diagnosis of Alzheimer's disease and multiple other co-morbidities: Heart Failure, Atrial Fibrillation, Hypertension, and Severe Tricuspid Valve Regurgitation. Morphine Sulfate was ordered on 9/23/14 for pain/sob- palliative. (Attachment 6) Resident # 16 suffered a seizure on 9/26/14 and her overall condition declined day by day. (Attachments 7-10) Resident #16 became comfort care on 9/28/14 rather than being actively treated medically. (Attachment 11) Facility staff was attentive to her every need including standard care of turning every 2 hours, bathing, dressing, feeding, providing incontinent care from the time of seizure until her death on 10/8/14. Review of the ADL grid for Resident #16 indicates staff participated in bed mobility which includes turning and repositioning (Attachment 12-14), in addition to validating the rapid decline in functional status. Resident #16's rapid development of pressure ulcers can be attributed to organ failure of the skin related to the dying process, therefore, clinically unavoidable.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>Resident #15 was observed in direct contact with the surface of a foot stool. During an interview, at that time, LPN #14 indicated she was going to remove the right leg immobilizer and perform a dressing change. The right leg of Resident #15 was observed, at that time, to have multiple circular indentations of various sizes. During an interview, at that time, LPN #14 indicated the indentations were caused by the sheep skin insert. LPN #14 was then observed to remove the dressing from Wound #1 and indicated, at that time, the wound had re-opened when the dressing was removed. During an interview, at that time, LPN #14 indicated a third wound was observed on the right leg located distal to Wound #2.</p> <p>Wound #3</p> <p>A "Nursing-New skin alteration assessment dated 2/23/15 at 8:56 P.M. indicated, Resident #15 experienced a "new dark purple area" below the bend of the right knee. The assessment lacked any documentation pressure relief was provided to the immobilized right leg.</p> <p>A Care Plan "...Stage 2 fluid filled blister below bend and to right of right knee..." dated 2/23/15 lacked any documentation pressure relief was provided to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>immobilized right leg.</p> <p>During an interview with the DON (Director of Nursing) on 2/23/15 at 9:42 A.M., the DON indicated the facility did not have a policy and procedure for assessing splints and braces. The DON further indicated, at that time, pressure relief should have been provided.</p> <p>A Policy and Procedure provided by the MD'S nurse on 2/24/15 at 12:35 P.M., read as follows: "...1. PURPOSE...reduce risk factors that may contribute to the development of pressure ulcers..."</p> <p>2. The clinical record of Resident #16 was reviewed on 2/23/15 at 9:10 A.M. The record indicated Resident #16 was admitted to the facility on 9/18/14 with diagnoses including, but not limited to, Alzheimer's disease.</p> <p>The Admission Nursing Assessment indicated Resident #16 experienced severe cognitive impairment, required the extensive assist of one staff, was at risk to develop pressure areas and/or experienced no areas of pressure.</p> <p>The Re-admission MDS (Minimum Data Set) assessment dated 9/25/14 indicated Resident #16 experienced severe cognitive impairment, required the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>extensive assistance of two staff for bed mobility, was at risk to develop pressure areas and/or experienced no areas of pressure.</p> <p>The Nursing Admission/Return assessment dated 9/18/14 indicated Resident #16 was admitted to the facility with no pressure related skin impairment.</p> <p>A Braden Scale risk assessment dated 9/20/14 at 9:00 P.M., indicated Resident #16 was at risk to develop pressure related skin impairment.</p> <p>A Nursing note dated 9/25/14 at 10:50 A.M. indicated, Resident #16 experienced a seizure.</p> <p>The concurrent Nursing notes from 9/28/14 at 10:41 A.M. through 9/30/14 at 10:41 A.M. were reviewed and the following was noted:</p> <p>A Nursing note dated 9/28/14 at 10:41 A.M. indicated, "...Res [resident] currently sitting in w/c [wheel chair] at nurse station talking to self..."</p> <p>A Nursing note dated 9/28/14 at 1:37 P.M. indicated, "...resting in bed with eyes closed..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>A Nursing note dated 9/29/14 at 9:38 A.M. indicated, "... remains in bed asleep..."</p> <p>A Nursing note dated 9/24/14 at 11:16 A.M. indicated, "...is still in bed asleep. Res noted to [sic] resting..."</p> <p>A Nursing note dated 9/30/14 at 10:35 A.M. indicated, "...remains in bed unresponsive...repositioned...has been unresponsive X [times] 2 days..."</p> <p>The Nursing notes from 9/28/14 at 10:41 A.M. through 9/30/14 at 10:35 A.M. lacked any documentation Resident #16 was repositioned and/or provided pressure relief to the heels, calves, and/or buttocks.</p> <p>A Care Plan for "Skin risk" dated 9/19/14 included the following interventions: "encourage meal/fluid intake, monitor labs as available, monitor skin daily during care, notify physician and family of any change in skin integrity, provide pressure reducing device to bed, serve diet as ordered, skin assessment at least weekly by nurse, skin assessment upon admission and then every shift for the first 3 days." The plan lacked any documentation to indicate the repositioning and/or pressure relief interventions had been implemented after</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>Resident #16 experienced a significant change in condition.</p> <p>A Nursing note dated 9/30/14 at 10:41 A.M. indicated, "...Noted a stage [sic] 2 pressure area measuring 5 cm [centimeters] X 4 cm to right heel et pressure area to left heel measuring 7.5 cm X 6 cm, both are fluid filled. Stage 2 pressure area to back of right calf measuring 1 cm X 1 cm, looks like a popped blister, surrounding tissue is red et blanchable. Stage 2 pressure area to right inner buttock measuring 4 cm X 4 cm, surrounding tissue is red et blanchable..."</p> <p>During an interview on 2/23/15 at 3:30 P.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate care had been provided to Resident #16 after a significant change in condition was experienced to prevent the development of pressure areas. The DON further indicated, at that time, repositioning and pressure relief should have been provided after Resident #17 experienced a significant change in condition.</p> <p>The Policy and Procedure for Wound Assessment provided by the HFA (Health Facilities Administrator) on 2/24/15 at 12:00 P.M. indicated Definitions of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
F 0318 SS=D Bldg. 00	<p>Wounds: ...II. Stage II pressure ulcer...May also present as an intact ...ruptured ...blister..."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review the facility failed to provide a range of motion program to a dependent resident with a contracture, in that, a resident with a impaired range of motion did not have a range of motion program in place for one of one resident reviewed for range of motion. (Resident #34)</p> <p>Findings include:</p> <p>On 2/18/15 at 11:26 A.M., Resident #34 was observed sitting up in a wheel chair in the east 1 lounge of the facility. Resident #34 was observed to have a contracture to the right elbow.</p>	F 0318	<p>Resident # 34 is presently being treated by therapy for development of a range of motion program for her right elbow. Resident #34 had repeatedly refused her range of motion program so the program was discontinued in December of 2014. Other residents with contractures have been reviewed and appropriate care plans are in place. On a weekly basis, a look back report from the electronic health record of all restorative programs will be printed and reviewed to identify those residents that are refusing their programs and referred to therapy for screens. In addition, walking rounds and therapy screens</p>	03/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635		
(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	
	<p>The clinical record for Resident #34 was reviewed on 2/23/15 at 8:00 A.M., diagnoses include, but were not limited to, fracture of humerus, osteoarthritis, depression.</p> <p>The Minimum Data Set assessment (MDS) dated 12/15/14, indicated Resident #34 required extensive assist of 2 persons for transfers, bed mobility and ambulation. The MDS indicated Resident #34 required extensive assist of one person with dressing.</p> <p>The care plans included, but were not limited to, "Activities: Resident prefers not to attend group activities due to: preference to stay in room as resident likes her privacy." (initiated 1/15/13) The documentation lacked any care plan addressing the contracture.</p> <p>During an interview with the Restorative Nurse on 2/23/15 at 8:25 A.M., she indicated Resident #34 did have a contracture to the right elbow. She further indicated Resident #34 was not on a range of motion program.</p> <p>During an interview with CNA #4 on 2/23/15 at 8:45 A.M., she indicated resident #34 did not receive range of motion. She further indicated Resident</p>		<p>will be completed in coordination with the MDS schedule quarterly. To ensure ongoing compliance, the QA tool Restorative Care Review (attachment G) will be completed weekly for 8 weeks then will be reduced to quarterly if substantial compliance is obtained as determined by the quality assurance committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>#34 at times went to the daily exercise program.</p> <p>A policy titled "Restorative Nursing Program Procedures" dated 9/1/04, included, but was not limited to, "A. Purpose 1. To provide services which promote the highest level of functioning in activities of daily living..." The policy continued and included "a. All residents will be assessed for appropriateness and placed on an informal or formal restorative program based upon their functional needs/capabilities."</p> <p>The activity participation log dated 1/1/15 through 2/24/15 for Resident #34 was reviewed on 2/24/15 at 10:50 A.M. The activity participation log lacked any documentation that Resident #34 had participated in the daily exercise group.</p> <p>On 2/24/15 at 10:55 A.M., during an interview with the Activity Assistant #3, she indicated, at times Resident #34 did attend the daily exercise class however, she did not participate. She further indicated since Resident #34 did not actively participate she did not count her in attendance.</p> <p>3.1-42(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635			
(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			
F 0323 SS=D Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided, and/or effective interventions were implemented, in that, a resident identified as at risk to experience a fall was not provided supervision and/or effective interventions were not implemented and experienced 5 falls for 1 of 3 residents who met the criteria for review of accidents. (Resident #66)</p> <p>Findings include:</p> <p>During an interview on 2/18/15 at 11:15 A.M., RN #1 indicated Resident #66 had experienced a fall on 2/13/15 while trying to self transfer from chair to wheelchair. RN #1 further indicated, at that time, Resident #66 was supposed to use the call light when assistance was needed, but usually didn't.</p> <p>On 2/19/15 at 9:48 A.M., Resident #66 was observed sitting in a wheelchair watching television in her room. The call light was observed, at that time, to be</p>	F 0323	<p>F-Tag 323 Free of Accident Hazards/Supervision/Devices: Miller's Merry Manor Rockport respectfully requests to informally dispute this citation. It is the policy of Miller's Merry Manor, Rockport to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents. Resident #66 remains in the facility. Resident is currently being seen by therapy. Care plan has been reviewed and updated. All residents are at risk to be affected. All residents with fall risk will be reviewed. All staff to be re-educated on fall prevention on 3/20/2015. The DON/Designee will be responsible to complete the QA tool titled "Fall Risk Management Review" (Attachment H) weeklyx4 weeks, then monthly thereafter to ensure ongoing compliance. Any identified issues will be immediately corrected and documented on facility QA Summary Log. Logs are reviewed during the monthly facility Quality Assurance Performance</p>	03/26/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635		
(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	
	<p>within reach.</p> <p>The clinical record of Resident #66 was reviewed on 2/23/15 at 2:42 P.M. The record indicated the diagnoses of Resident #66 included, but were not limited to, dementia.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 12/23/14 indicated Resident #66 experienced minimal cognitive impairment, required the supervision of one staff member for transfers and room mobility. The MDS further indicated Resident #66 experienced unsteady balance during walking and transfers and/or had a history of falls.</p> <p>A undated Care Plan for "Fall Risk" included the following interventions: "...encourage and assist with wearing non-skid footwear...encourage resident to use handrails or assistive devices properly...monitor for changes in gait/positioning...notify MD [physician] of changes in condition...notify Therapy of changes in condition...Reassess fall risk factors annually and PRN [as needed]...Reinforce need to call for assistance..."</p> <p>Fall #1: A Post Occurrence Fall Risk Assessment dated 11/8/14 indicated</p>		<p>Improvement meeting to ensure ongoing compliance. Informal Dispute for F-323Resident #66 did experience several falls as noted by the examples in the citation. Resident had history of falls prior to admission. Has been seen by orthopedics. Has had repeated injections for the left knee. Resident does have some cognitive impairment and will attempt to get up on her own and transfer. Staff has provided re-education on importance of having assist to decrease her risk for falls. The facility did follow policy with each fall occurrence. The resident was assessed, the IDT met to determine the root cause of the falls, an intervention was added to the care plan and on going supervision and assistance with care was provided to the resident. Fall 11/8/14 Went to sit on bed and slipped to floor Root Cause: Bed not flush against wall and bed rolled. Intervention: Be sure bed flush to wall and locks on. Fall 11/11/14 Transferring self from w/c to recliner in room. Root cause: Self transferred and knee gave out. Stated didn't call for help because she couldn't reach call light. The light was attached to lamp by her recliner. Intervention: Keep light where it can be easily accessible from w/c or recliner. Fall 11/15/14 Nurse and CNA assisting resident onto scale to weigh her and her knee gave out. Sat down on the floor.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635			
(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			
	<p>Resident #66 experienced an unwitnessed fall on 11/8/14 at 10:30 P.M. in the resident's room. The assessment further indicated, "...Summary of occurrence...Resident rang call light...observed resident sitting on floor with back next to side of bed...stated ' I went to sit on the bed and the bed was not up against the wall like it usually is...I went to sit down it rolled back on me...Root Cause: Bed was not flush against wall and when resident went to transfer...to the bed from...w/c [wheel chair], bed rolled causing resident to slide off side of bed..."</p> <p>During an interview with the MDS nurse on 2/23/15 at 2:00 P.M., the MDS nurse indicated Resident #66 was at risk to experience a fall and further indicated, at that time, the immediate intervention implemented to ensure the safety of Resident #66 was to ensure the bed was kept in locked position.</p> <p>Fall #2: A Post Occurrence Fall Risk assessment dated 11/15/14 indicated Resident #66 experienced a fall on 11/15/14 at 3:40 P.M. in the resident's room. The assessment further indicated, "...CNA...was going to weigh resident...Res [resident] had...walker behind... because...was sitting in it. Res stood up with assistance from [sic] CNA</p>		<p>Root cause: Knee gave out Intervention: Resident to be weighed on w/c scale. Fall 11/28/14 Found on floor in room. Root cause: Trying to transfer self and knee gave out. Intervention: Provided elastic bandage to knee for support. Fall 2/13/15 Found on floor in room. Stated was getting into her w/c from the recliner and knee gave out and she sat on the floor. Root cause: Attempting self transfer and knee gave out. Intervention: Resident educated by therapy regarding she must have assistance for transfers. Also update to orthopedics regarding injection for knee. (attachment 15) Resident still has non-compliance and will attempt to transfer herself. Therapy has been attempted and a brace was provided for the resident but she refused to use this in the past. (attachment 16) Resident has now been started back on therapy and is participating at this time. A new type of brace is being tried for the left knee. (attachment 17) We continue to monitor resident for any changes. Will continue to review any fall issues and implement interventions as recommended by IDT. Assist is provided with transfers and resident encouraged to call staff when she wants to get up or transfer. Resident has history of non-compliance and still at times this is an issue. Her plan has been reviewed and updated. The</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>on one side and this nurse on the other. Res attempted to stand up on the stnading [sic] scale and stated...'knee was giving out' and tried to sit back down. Res walker, which would not lock, rolled backwards and res went straight down on...buttocks...Root cause: Resident knee giving out when standing on stand up scales."</p> <p>During an interview on 2/23/15 at 2:05 P.M. the MDS nurse indicated the immediate intervention implemented to ensure the safety of Resident #66 was to weigh the resident on the wheelchair scales.</p> <p>Fall #3: A Post Occurrence Fall Risk assessment dated 11/28/14 indicated Resident #66 experienced an unwitnessed fall on 11/28/14 at 3:00 P.M. in the resident's room. The assessment further indicated, "This nurse entered room to answer call light et noted res lying on floor on...back...when asked what...was trying to do at the time of the fall res stated...was trying to transfer from lounge chair to...w/c and 'my bad knee gave out on me'...Root Cause...knee gave way...</p> <p>During an interview on 2/23/15 at 2:10 P.M. the MDS nurse indicated the immediate intervention implemented to ensure the safety of Resident #66 was to</p>		<p>facility will make all attempts to help resident regain ability for safe transfers and also to keep her free from any injury related to falls.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>place a elastic bandage on the resident's knee.</p> <p>Fall #4: A Post Occurrence Fall Risk assessment dated 1/11/15 at 7:30 A.M. indicated Resident #66 experienced an unwitnessed fall in the resident's room and further indicated, "Was transfering [sic] self from recliner to w/c...Root cause: ...knee gave out..."</p> <p>A Nursing note dated 1/11/15 at 7:30 A.M. indicated Resident #66 experienced an unwitnessed fall in the resident's room and further indicated, "...res was noted to be sitting on the floor in front of...recliner...Res states...wanted to drink...coffee and was moving to...wheelchair to get closer to it. The res bedside table was noted to be sitting right beside of both chairs. When asked why...didn't use...call light first, res stated it was too far away. Res call light it was attached to the lamp sitting beside to...recliner. This nurse untied call light and draped it onto...recliner where it could be more easily reached from...recliner and wheelchair..."</p> <p>During an interview on 2/23/15 at 2:15 P.M. the MDS nurse indicated the immediate intervention implemented to ensure the safety of Resident #66 was to place 2 call lights in room, one in reach at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>all times.</p> <p>Fall #5 A Nursing Progress note dated 2/13/15 at 5:39 P.M. indicated Resident #66 experienced an unwitnessed fall in her room and further indicated, "...CNA...went to res room...res was noted to be lying on floor. Res stated she was trying to transfer herself from her recliner to her wheelchair. Res then stated she felt her knee "going out" and sat down on the floor. Res stated that she then laid down and "scoted herself" over to where her call light was. Res call light was lying beside her recliner..."</p> <p>During an interview on 2/23/15 at 2:25 P.M., the MDS nurse indicated the immediate intervention implemented to ensure the safety of Resident #66 was to have therapy to call the orthopedic doctor and educate the resident on safety interventions. The MDS nurse further stated, at that time, the interventions were not successful, "because [Resident #66] continues to stand up independently."</p> <p>During an interview on 2/24/15 at 11:00 A.M., the DON (Director of Nursing) indicated Resident #66 experienced repeated fall due to the resident's impulsivity and non-compliance with safety interventions.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
F 0329 SS=D Bldg. 00	<p>The Policy and Procedure for Fall Management provided by the HFA (Health Facilities Administrator) on 2/24/15 at 12:00 P.M. indicated, "...2. Procedure...D. Update the plan of care each time there is a change in intervention and communicate it to staff.</p> <p>3. Post Fall Investigation A...III Determine what new or revised interventions will be implemented to reduce the risk of further falls and/or injuries from falls..."</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635			
(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			
	<p>receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication was clinically indicated, in that, the blood pressure was not monitored for a resident who received an anti-hypertensive medication for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #7)</p> <p>Findings include:</p> <p>Resident #7 was observed on 2/19/15 at 10:26 A.M., sitting in the bedroom in a chair, in no apparent distress.</p> <p>The clinical record of Resident #7 was reviewed on 2/23/15 at 12:19 P.M. The record indicated the diagnoses of Resident #7 included, but were not limited to, hypertension (high blood pressure).</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 11/4/14 indicated Resident #7 experienced hypertension.</p> <p>The Plan of Care dated 1/27/14 for, "Multiple Chronic Cardiovascular...HTN [hypertension]..."included, but was not</p>	F 0329	<p>F-Tag 329: Unnecessary Medications: Miller's Merry Manor Rockport respectfully requests to informally dispute this citation. It is the policy of Miller's Merry Manor, Rockport that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose, without adequate indication for use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of reasons.</p> <p>Resident #7: Medication regimen has been reviewed by physician to ensure that resident is free from unnecessary medication. Resident is still receiving the medication. Blood pressure monitoring in place. Care plan reviewed. All residents who are prescribed anti-hypertensive medication requiring monitoring of blood pressure are at risk to be affected. All residents receiving antihypertensive medication will be reviewed to ensure any specific orders for blood pressure monitoring are being completed. Nurses re-educated on following physician orders as indicated for monitoring of antihypertensive medications. The QA Audit Tool Services Per</p>	03/26/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635			
(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			
	<p>limited to, interventions of Administer medications as ordered...Monitor vital signs weekly and PRN [as needed]..."</p> <p>The January Physician's Order recap included, but was not limited to, an order for, "...Clonidine [a medication to treat high blood pressure] 0.1 mg [milligram] give 1 tablet by mouth two times a day for HTN [hypertension]...Hold if SBP [Systolic blood pressure] less than 110..."</p> <p>The February 2015 MAR (Medication Administration Record) indicated Resident #7 received, "...Clonidine 0.1 mg...two times daily for HTN...Hold if SBP less than 110..." from February 1 through February 22, 2015. The MAR lacked any documentation the blood pressure of Resident #7 was checked prior to the administration of the Clonidine.</p> <p>A Vital Sign report from 2/1/15 through 2/23/15 provided by the MDS nurse on 2/23/15 at 12:00 P.M., indicated the blood pressure of Resident #7 had been checked on 2/2/15, 2/8/15, 2/16/15, and 2/23/15. During an interview, at that time, the MDS nurse indicated the blood pressure of Resident #7 was checked on a weekly basis.</p> <p>The Mosby's 2014 Nursing Drug</p>		<p>Plan of Care (Attachment I) will be completed by the DON/Designee weekly for eight weeks then monthly thereafter until issue is deemed resolved by the QA Committee. Informal Dispute for F-329 F329: The facility respectfully requests a paper review for this cited deficiency. We request the example cited in F329 be moved to F282. Resident #7 has diagnosis of hypertension. The resident is receiving clonidine 0.1mg twice daily for the control of her hypertension. Medication is to be held if SBP<110. The facility did fail to monitor the blood pressure prior to administration of each dose. However, the resident's blood pressure was being monitored at least weekly. As noted in the blood pressure log provided (attachment 18), the resident's SBP has never been <110. In closing, the medication was medically necessary. Blood pressure was being monitored, however staff did fail to follow physicians orders to check before each dose administered. There were no negative outcomes to the resident. Therefore the facility requests the removal of F329 be honored and the example moved to the F282 citation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635			
(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			
F 0371 SS=F Bldg. 00	<p>Handbook pages 322-324 indicated, "...Clonidine...Uses: hypertension....Nursing Considerations Assess: Hypertension: B/P [blood pressure]..."</p> <p>During an interview on 2/23/15 at 3:00 P.M., the DON (Director of Nursing) indicated the blood pressure of Resident #7 should have been checked before the administration of Clonidine.</p> <p>The Policy and Procedure for Medication Administration provided by the HFA (Health Facilities Administrator) on 2/24/15 at 12:00 P.M. indicated, "...17. Complete necessary assessments before administering medications..."</p> <p>3.1-48(a)(3)</p> <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, interview and record review, the facility failed to ensure the kitchen floors, dish storage areas, and walls were maintained in a sanitary</p>	F 0371	<p>Sanitation: F 371 The cabinet above hand washing sink was cleaned and sanitized and the bug was removed. The floors were cleaned, buffed,</p>	03/26/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635		
(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	
	<p>manner, in that, debris was observed around tables and floor in kitchen on 3 of 3 kitchen observations. This had the potential to affect 57 of 57 residents at the facility.</p> <p>Findings Include:</p> <p>1. The cabinet above the hand washing sink was observed on 2/18/15 at 11:30 A.M., 2/19/15 at 10:55 A.M., and 2/20/15 at 11:40 A.M. During all three days of observation located on the shelf was a dead cockroach and insect droppings.</p> <p>2. The kitchen floors were observed on 2/18/15 at 11:35 A.M., 2/19/15 at 11:00 A.M., and 2/20/15 at 11:45 A.M. During all observations the floor was covered with loose food around food prep areas and a sticky layer of debris, was observed around table legs of the food preparation table, oven, and reach in refrigerator equipment legs in the entire kitchen. Loose debris and a black slick substance were also observed under the sink and dishwasher on all three days. When the area was wiped with paper towel loose debris came up.</p> <p>3. The walls beside the reach in refrigerator and surrounding the fire</p>		<p>and waxed according to floor cleaning policy. The walls beside the reach in refrigerator were cleaned and painted on 2/21/15. The tray line cupboard was dusted 2/20/2015. All residents had the potential to be affected by the alleged deficient practice. The facility has updated their cleaning schedules for the department and will re-educate all dietary staff on sanitation procedures and new schedules including the hand sink, floors, walls, and cupboards. (Attachments J,K,L,M) The dietary sanitation will be monitored with the Sanitation Services Review QA tool by the dietary manager or designee weekly for 4 weeks and then at least monthly thereafter with spot checks by administrator, regional vice president, consultant dietitian, or corporate quality assurance nurse. (Attachment N). Any necessary corrections will be made immediately or placed on the QA log to be scheduled for repair/cleaning. Results will be reviewed by the QA committee and any trends identified will be addressed with appropriate staff.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>extinguisher were observed on 2/19/15 at 11:15 A.M., and 2/20/15 at 11:50 A.M. The wall had a tan colored splatter on them.</p> <p>4. During an observation on 2/20/15 at 11:56 A.M., the Tray line cupboards were observed to be covered with a layer of dust. The tray line cupboard was wiped with a paper towel the dust easily came up.</p> <p>On 2/20/15 at 12:40 P.M., during an interview with the dietary manager she indicated they used a cleaning schedule and each shift had regular assignments and they would be signed off when completed. She confirmed that the deceased bug on the shelf was a cockroach and indicated they had identified and they were working on correcting the issue. She further indicated the floors were cleaned every shift and they would be doing thorough cleaning.</p> <p>On 2/23/15 at 11:25 A.M., during an interview with the Administrator she indicated she had told of the concerns in the kitchen. She indicated the dietary department had a set cleaning routine and staff had been educated on sanitation requirement since the discovery of the pest concern.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
F 0458 SS=D Bldg. 00	<p>A document titled "CLEANING SCHEDULE FOR THE MONTH OF FEB [February] 2015" was provided by the dietary manager on 2/23/15 at 10:45 A.M. It included, but was not limited to, "Day Server Will be responsible for cleaning these areas on a Daily basis" the areas of responsibility included, but was not limited to "Trayline [sic] Cupboards" The document also included "Night Server will be responsible for cleaning these areas on a daily basis" the areas of responsibility included, but was not limited to "Sweep & Mop Floor".</p> <p>A policy titled "Dietary Policy and Procedure Manual" dated 1/20/2013 was provided by the Administrator on 2/13/15 at 12:49 P.M. The policy included, but was not limited to, "It is policy that the Dietary Manager is responsible for the supervision and training of employees for cleaning and sanitizing, in the Dietary Department."</p> <p>3.1-21(1)(2) 3.1-21(1)(3)</p> <p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635		
(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	
	<p>single resident rooms.</p> <p>Based on record review, observation, and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple residents' rooms and 100 sq ft in single occupancy rooms. This was evidenced in 14 of 43 resident rooms in the facility. Rooms 3, 5, 7, 9, 13, 17, 19, 21, 22, 23, 24, 25, 10, 16.</p> <p>Findings include:</p> <p>The Bed Inventory dated 2/19/14, was provided by the Administrator on 2/20/15 at 10:09 A.M., and indicated the following rooms had room size waivers. The Waiver certification dated 2/13/14, was reviewed at that time.</p> <p>During an enviomental tour the following room sizes of observed rooms:</p> <p>*1. Room #3 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*2. Room #5 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*3. Room #7 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*4. Room #9 2 beds 154.65 sq ft</p>	F 0458	<p>The facility has requested a waiver for the rooms cited in the survey. The facility does not feel that the size of the rooms cited has any adverse affect on the residents in those rooms. CMS has granted the waiver in years past.</p>	03/26/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	SNF/NF 77.32 sq ft per resident *5. Room #13 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *6. Room #17 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *7. Room #19 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *8. Room #21 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *9. Room #22 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *10. Room #23 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *11. Room #24 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *12. Room #25 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
F 0465 SS=E Bldg. 00	<p>These room sizes were verified by the Administrator on 2/20/15 at 10:09 A.M., as well as the room sizes of two additional single occupancy rooms which were observed to have less than 100 sq ft as follows:</p> <p>*13. Room #10 1 bed 90.52 sq ft per resident</p> <p>*14. Room #16 1 bed 90.52 sq ft per resident</p> <p>3.1-19(1)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure the environment was sanitary and in good repair. In that, walls, and/or floors and/or baseboards were soiled and/or in disrepair for 2 of 5 survey days on 1 of 2 units. (Room #5, 7, 9, 14, 17, and 23)</p> <p>Findings include:</p> <p>1. Resident Room #5 was observed on 2/18/15 at 11:45 A.M. and on 2/23/15 at</p>	F 0465	<p><u>F465 Environmental:</u> Resident room #5 and room #23 baseboard heater covers were fixed/replaced. Baseboard in Room #23 was also fixed. The bathroom between room #7 and room #9 floor and bathroom in room #14 floor were cleaned according to bathroom cleaning policy and procedure. Room #17 floors were cleaned according to floor cleaning policy and procedure. All flooring in each resident room</p>	03/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635			
(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			
	<p>10:00 A.M., during both observations the base board heater cover was observed to be off.</p> <p>2. Resident Room #23 was observed on 2/18/15 at 12:45 P.M., and on 2/23/15 at 10:20 A.M. During both observations the baseboard heater cover was observed to be off. The baseboards leading into the bathroom and to the right of room door was chipped and/or missing.</p> <p>3. The shared resident bathroom located in between resident Rooms #7 and #9 was observed on 2/18/15 at 1:41 P.M. and on 2/23/15 at 10:05 A.M. During both observations the floor was observed to have a dark, gritty substance in the corners of the bathroom. On 2/23/15 at 10:07 A.M., the Housekeeping Supervisor was interviewed, she indicated the areas were stained and would not come up. When wiped with a moist paper towel the substance came up easily.</p> <p>4. The resident's bathroom in Room #14 was observed on 2/19/15 at 10:01 A.M., and 2/23/15 at 9:54 A.M., during both observations the bathroom floor was observed to have a dark gritty substance in the corners of the bathroom.</p> <p>5. The floors in Resident room #17 were</p>		<p>and bathroom was replaced by 3/12/2015. It is the practice of this facility to maintain the facility in a safe and sanitary condition. All residents have the potential to be affected by this practice. To ensure ongoing compliance, the facility will check each resident room and bathroom to ensure it is in safe and sanitary conditions utilizing the Maintenance Services Review & Housekeeping Services Review quality assurance tools. Any room found to need repairs will be placed on a quality assurance log and scheduled for repair. The facility will inspect resident rooms weekly for 4 weeks, monthly for 3 months, then at least quarterly thereafter. The maintenance supervisor or designee will be responsible to complete the Maintenance Services Review. (attachment O). The housekeeping supervisor or designee will be responsible for completing the housekeeping services review quality assurance tool. (attachment P). Any problems noted will be corrected immediately or placed on quality assurance log to be repaired/addressed. Results will be reviewed by the quality assurance committee and any</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635		
(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	
F 0469 SS=F Bldg. 00	<p>observed on 2/19/15 at 9:46 A.M. and on 2/23/15 at 10:30 P.M., during both observations the edges of the room and corner was observed to be soiled.</p> <p>On 2/23/15 at 11:25 A.M., the facility Administrator was made aware of the concerns. She indicated it was the facility policy to provide a clean environment.</p> <p>A policy titled "Cleaning Bathrooms Procedure" dated 10/21/13 was provided on 2/24/15 at 10:01 A.M. by the Administrator. It included, but was not limited to, " It is the policy of Miller's Health Systems, Inc. to maintain a clean environment..." The policy continued and included "...IX. Mop the floor using floor cleaner paying attention to the base of and the front of toilet, behind the toilet and corners."</p> <p>An undated policy titled "Resident Room Cleaning" wows provided on 2/24/15 at 10:01 A.M., by the Administrator. It included, but was not limited to, "5) Sweep and mop floor."</p> <p>3.1-19(f)</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p>		trends identified will be addressed with the appropriate staff.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility was free of pests, in that, a deceased cockroach and insect droppings were observed for 3 of 3 observations kitchen observations. This had the potential to effect 57 of 57 in the facility.</p> <p>Findings Include:</p> <p>The cabinet above the hand washing sink was observed on 2/18/15 at 11:30 A.M., 2/19/15 at 10:55 A.M., and 2/20/15 at 11:40 A.M. During all three days of observation located on the shelf was a dead cockroach and insect droppings.</p> <p>On 2/20/15 at 12:40 P.M., during an interview with the dietary manager she indicated they used a cleaning schedule and each shift had regular assignments and they would be signed off when completed. She confirmed that the deceased bug on the shelf was a cockroach and indicated they had identified and they were working on correcting the issue. She further indicated the floors were cleaned every shift and they would be doing thorough cleaning.</p> <p>On 2/23/15 at 11:25 A.M., during an</p>	F 0469	<p>Bug was removed. All residents had the potential to be affected by the alleged deficient practices.</p> <p>All areas in kitchen were sanitized and cleaned. The facility will follow their pest control policy that states the facility will maintain an effective contract with a pest control service for the manner of preventative maintenance. Maintenance to seal cracks around corner guards.</p> <p>The Pest Control Services Review QA tool will be monitored by the dietary manager or designee for 4 weeks and then at least monthly thereafter (attachment Q). Any necessary corrections will be made immediately or placed on the quality assurance log to be scheduled for repair/cleaning. Results will be reviewed by the Quality Assurance committee and any trends identified will be addressed with appropriate staff.</p>	03/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
	<p>interview with the administrator she indicated she had been told about the concerns in the kitchen. She indicated the facility had experienced some concerns with cockroaches in the kitchen. She indicated they had been receiving monthly preventive services. She further indicated the dietary department had a set cleaning routine and staff had been educated on sanitation requirement since the discovery of the pest concern.</p> <p>The facility pest control agreement dated 9/1/08, indicated the facility was to receive monthly services to address, common household pests, including but not limited to, roaches.</p> <p>A monthly pest inspection report for 11/6/14 and 12/12/14 were reviewed. The note indicated live and deceased cockroaches were found in the kitchen. Recommendations made by the exterminator include, but was not limited to "Seal Cracks Around Corner Guards"</p> <p>An undated policy titled "Pest Control Policy" was provided by the Administrator on 2/24/15 at 10:01 A.M. included, but was not limited to, " It is the policy of Miller's Merry Manor to maintain an effective contract with a pest control service for manner of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
--	--

(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
F 0500 SS=D Bldg. 00	<p>preventative maintenance." 3.1-19(f)(4)</p> <p>483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section.</p> <p>Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.</p> <p>Based on interview and record review, the facility failed to obtain a written agreement between the renal dialysis provider and the facility which outlined services that would be provided for residents by the facility and/or the dialysis service provider, and which designated responsibilities that would be assumed by the dialysis service provider and/or the facility. (Resident #28)</p>	F 0500	<p><u>F500-No dialysis contract:</u> The facility has requested a contract with Davita Dialysis of Newburgh, Indiana. This resident receiving outside dialysis services has the potential to be affected. The facility will obtain a contract for outside resources prior to accepting a resident needing these outside resources. Facility to utilize the Operations QA audit tool</p>	03/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635		
(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	
	<p>Findings included:</p> <p>On 2/18/15 at 10:17 A.M., during entrance conference with the Administrator, the Administrator indicated Resident # 28 received dialysis services.</p> <p>During an observation on 2/18/15 at 11:20 A.M., Resident #28 was sitting in her room in her recliner chair.</p> <p>The clinical record of Resident #28 was reviewed on 2/19/15 at 11:48 A.M. The record indicated Resident #28 was admitted to the facility on 9/16/14 and the diagnoses of Resident #28 included but were not limited to, renal dialysis status and acute respiratory failure.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 9/23/14 indicated Resident #28 was receiving dialysis treatments.</p> <p>Current physician orders dated 1/1/15, indicated hemodialysis 3 times a week on Monday, Wednesday, and Friday.</p> <p>During an interview on 2/20/15 at 10:09 A.M., the Administrator indicated the facility did not have a contract/agreement with the dialysis provider. She indicated she had contacted the dialysis provider a</p>		<p>(attachment R) for outside resources to be utilized weekly for 4 weeks, then monthly for 3 months, then quarterly thereafter. Any issues noted will be corrected immediately or placed on the QA log to be corrected. Results will be reviewed by the QA committee and any trends identified will be addressed with appropriate staff.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635		
(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	
	<p>couple of months ago regarding a contract/agreement with the facility. She indicated she had not received a reply from the dialysis provider in regard to a contract for dialysis services.</p> <p>On 2/24/15 at 8:45 A.M., during interview the Director of Nursing (DON) she indicated she was unaware of which services the dialysis provider would provide and which services the facility was responsible for in regard to Resident #28 receiving dialysis services.</p> <p>3.1-13(m)(1) 3.1-13(m)(2)</p>				