STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	2901 W 37TH AVE HOBART, IN 46342

(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
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 12,13,14, 18,19 and 20, 2013 Facility number: 000154 Provider number: 155251 AIM number: 100289680 Survey team: Kathleen (Kitty) Vargas, RN-TC Heather Tuttle, RN Shannon Pietraszewski, RN Regina Sanders, RN (2/14, 2/18, 2/19, 2/20, 2013) Janelyn Kulik, RN (2/12/13) Census bed type: SNF: 9 SNF/NF: 58 Total: 67 Census payor type: Medicare: 9 Medicaid: 46 Other: 12 Total: 67 These deficiencies reflect state findings cited in accordance with 410	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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	IAC 16.2. Quality review completed on February 28, 2013, by Janelyn Kulik, RN.			

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review, and interview, the facility failed to notify a physician of a resident's request for an antacid related to abdominal pain for 1 of 3 residents reviewed for pain	F000157	**The facility requests a face to face IDR for F-Tag 157. The facility is requesting a face to face IDR review to have the tag deleted. The additional information was all available**	03/22/2013

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	of the 4 residents who met the criteria for pain. (Resident #26) Findings included: Resident #26 was interviewed on 2/13/13 at 9:31 a.m. Resident #26 indicated she had not been feeling well, her stomach had been aching, and she had not been eating. The resident indicated she had been trying to eat but had gotten sick to her stomach. The resident indicated the nursing staff was aware and told her the stomach pain was due to her taking medications and not eating. The resident indicated her symptoms had been going on for a while. She also indicated she had not seen the doctor since her last hospitalization in December. Resident #26's record was reviewed on 2/14/13 at 10:46 a.m. Resident #26's diagnoses included, but were not limited to, hypertension, anxiety, gastrointestinal (stomach) discomfort, atrial fibrillation (irregular heart rhythm), neuropathic pain, respiratory failure and depression. A care plan for gastrointestinal discomfort was initiated on 8/17/12. The interventions on 2/5/13, indicated the physician had given orders to		**during the time of the survey, but was never requested by the surveyor. The facility was essentially blind sided at the exit conference that notification of physician was a concern for resident # 26 and would be cited during this survey cycle. F-Tag 157 Notify of Changes** It is the policy of Miller's Merry Manor, Hobart to promptly inform the resident; consult with resident's physician, notify resident's legal representative or an interested family members when there is a significant condition change in the resident's physical, mental, or psychosocial status and or/the need to alter treatment significantly. Resident # 26 : Physician will be notified if resident has a significant condition change in physical, mental, or psychosocial status and/or the need to alter treatment significantly. *All residents are at risk to be affected by the deficient practice.* The nurse managers will complete an audit of all active resident charts by 3/22/13 to ensure any significant change in conditions/status have been communicated to the physician and family per policy. All licensed nursing staff will be in-serviced on facility policy for "Notification of Changes" (Attachment A) by 3/22/13. Nurses will be instructed to document in the EMR any significant condition change in a	

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	reduce multiple medications, monitor for discomfort, and notify the physician of any abnormal findings. On 2/14/13 at 11:48 a.m., Resident #26 indicated she still wasn't feeling well. On 2/14/13 at 12:07 p.m., Resident #26 informed LPN #3 her stomach hurt and she wanted the nurse to give her something for the pain. The Nurse Consultant informed the resident she would get a "Shasta" (clear carbonated cola) for the resident, indicating it had helped the resident's stomach in the past. The resident indicated she wanted an antacid. LPN #3 informed the resident she didn't have an order for an antacid. She offered the resident zofran (nausea medication) and indicated to the resident she would call the doctor and ask him for an order for the antacid. LPN #3 was interviewed on 2/14/13 at 1:40 p.m. LPN #3 indicated she had not contacted the physician "yet" regarding the resident's symptoms. During this time, the resident indicated she still had some abdominal pain. The February 2013 MAR (Medication		resident's physical, mental, or psychosocial status and or/the need to alter treatment significantly. The nurse managers review the EMR 24 hours condition report daily to ensure that significant changes in status are communicated to physician per policy. The DON or other designee will be responsible to complete the QA tool titled "24 Hour Condition Review" (Attachment B) daily x 1week, then bi-weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected and logged on facility QA tracking log. The QA tracking logs are reviewed during the facility monthly QA meeting to ensure ongoing compliance.	

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	Administration Record) was reviewed on 2/19/13 at 12:00 p.m. There was an order for an antacid that was dated 2/18/13. The nursing notes dated 2/14/13 at 10:30 p.m. and 2/15/13 at 1:21 p.m., did not indicate the physician was notified of the residents abdominal discomfort and the resident's request for an antacid. There was no documentation that indicated when the physician was notified. The Director of Nursing was interviewed on 2/19/13 at 1:00 p.m. The DON indicated she did not know why there was a delay in the antacid order from last week. 3.1-5(a)(2) 3.1-5(a)(3)			

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F000164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.			
	Based on observation, record review, and interview, the facility failed to ensure each resident's privacy was maintained related to medication wrappers left on top of the medication cart and the privacy curtain in the West Unit Shower room which did not close completely for 1 of 11 residents	F000164	**F-Tag 164: Personal Privacy** It is the policy of Miller's Merry Manor, Hobart that residents have the right to personal privacy and confidentiality or his or her personal and clinical records. **Resident #44 and #46**: LPN #4 has been re-educated on procedure for maintaining resident privacy during	03/22/2013

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	observed for medication pass and for 2 of 3 shower rooms. This had the potential to effect 34 residents who resided on the West Unit. (Resident #44 & #46 and the West Unit shower room) Findings include: 1. During Medication pass with LPN #4 on 2/14/13 at 9:05 a.m., the LPN was observed preparing medications for Resident #46. The LPN removed each of the resident's medications from an individual dose wrapper. The wrappers indicated the name of the resident, the name of the drug, the dose and the the time the medication was to be given. LPN #4 left the resident's medication wrappers on top of the cart and walked into the resident's room to administer his medications. After the medication pass, the LPN then threw away the wrappers in a white opaque paper bag that was taped on the side of the cart. 2. During medication pass with LPN #4 on 2/14/13 AT 9:18 a.m., the LPN was observed preparing medications for Resident #44. The wrappers indicated the name of the resident, the name of the drug, the dose and the the time the medication was to be		medication administration. LPN#4 will not leave opened wrappers out on the medication cart when cart is unattended. **West Shower Room**: New privacy curtains will be hung in the shower room by 3/22/13 that will completely block the opening to the shower stalls to ensure resident privacy is maintained when in use. *All residents are at risk to be affected by the deficient practice.* All nursing staff will be in-serviced on a resident's right to "Privacy" on or before 3/22/13. Charge nurses will be instructed on maintaining residents privacy during medication pass by covering packages/ discarding packages in opaque bag to prevent others from reading wrappers when the med cart is unattended by nurse. The nurse managers will participate in routine walking rounds on various shifts at medication administration times to monitor that nurses are maintaining privacy. Nursing assistants will be responsible to make sure curtains are pulled in shower room completely to maintain resident privacy during showers. The corrective action will be monitored utilizing the QA tool "Quality Care Review" (Attachment C). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns	

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	given. LPN #4 left the resident's medication wrappers on top of the cart and walked into the resident's room to administer her medications. After the medication pass, the LPN then threw away the wrappers in a white opaque paper bag that was taped on the side of the cart. Interview with LPN #4 on 2/14/13 at 9:30 a.m., indicated she was aware she was supposed to throw the medication wrappers in the white paper bag on the side of the cart or cover them with the medication book before entering the resident's room. 2. During the Environmental Tour on 2/19/13 at 9:35 a.m. through 11:35 a.m., with the Administrator and the Maintenance and Housekeeping Supervisors, the West Unit Shower room was observed to have two shower stalls. The shower stalls were divided by a tiled wall. Each shower stall had a privacy curtain, which did not cover the opening to the shower stall, leaving a 10-12 inch gap at the opening of the shower stall. During an interview at the time of the observation, the Maintenance Supervisor indicated if others were in the shower room they would be able to see into the shower stall when the curtain was pulled.		identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.	

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	3.1-3(p)(1)			

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F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to maintain each resident's dignity related to ensuring the resident's indwelling Foley catheter drainage bag was covered as well as ensuring residents were dressed in street clothes if desired for 3 of 3 residents reviewed for dignity of the 7 residents who met the criteria for dignity. (Resident's #19, #48, and #80) Findings include: 1. On 2/12/13 at 10:54 a.m., and 2:00 p.m., Resident #19 was observed lying in bed. At those times the resident's urinary catheter bag was facing the door and was not covered or in a dignity bag. On 2/13/12 at 8:45 a.m., the resident was lying in bed. The resident's Foley catheter bag was not covered or in a dignity bag. On 2/14/13 at 6:00 a.m., 7:20 a.m., and 9:15 a.m., the resident was in	F000241	**F241 Dignity and Respect of Individuality:** It is the policy of Miller's Merry Manor Hobart to promote care for the residents in an environment that maintains or enhances each resident's dignity and respect in full recognition of the his or her individuality. Resident: # 19 and # 48: Foley catheter bags will be covered to ensure residents dignity. Resident: # 80: will be dressed in street clothes daily per preference. *All residents in the facility have the potential to be affected by this deficient practice*. The facility will educate all nursing staff regarding the importance of dressing residents daily in street clothes unless otherwise indicated by resident preference on or before 3/22/13. Nursing staff will also be instructed to place urinary drainage bags in a covered bag to ensure that dignity is maintained at all times. Bags to cover a foley drainage bag will be placed on both sides of the resident's bed and one on	03/22/2013

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	bed. At those times the resident's urinary catheter bag was facing the door and was not covered or in a dignity bag. On 2/19/13 at 8:24 a.m., the resident was in bed. The resident's Foley catheter bag was not covered or in a dignity bag. Interview with CNA #2 on 2/19/13 at 10:20 a.m., indicated she was aware the Foley catheter drainage bag had to be in the dignity bag. She further indicated the dignity bag was on the side of the resident's chair that morning while the resident was in bed. The record for Resident #19 was reviewed on 2/14/13 at 6:09 a.m., The resident's diagnoses included, but were not limited to, Alzheimer's disease and senile dementia. Review of Physician Orders dated 1/2/13, indicated Foley catheter: ensure catheter bag is below the waist, covered and tubing was not touching the floor. Interview with LPN #4 on 2/19/13 at 10:30 a.m., indicated the drainage bags for the Foley catheters should be covered and placed in dignity		wheelchair to enable ongoing compliance on or before 3/22/13. The administrator, social service designee, and nurse managers will be responsible to participate in routine walking rounds of the facility on varying shifts and at different times to monitor that residents are treated with and provided care in a dignified manner. The corrective action will be monitored utilizing the QA tool "Quality Care Review" (Attachment C). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.	

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	bags. 2. Resident #80 was observed on 2/12/13 at 1:10 p.m. She was seated in a gerichair in her room, she was in a hospital gown, she was not dressed in street clothes. The resident was observed in a gerichair in her room on 2/13/13 at 9:48 a.m., she was dressed in a gown, she was not dressed in street clothes. The resident was observed on 2/14/13 at 10:53 a.m., she was not dressed in street clothes, she wore a hospital gown. The resident was seated in a gerichair in her room on 2/18/13 at 1:26 p.m., she was dressed in a hospital gown, she was not dressed in street clothes The record for Resident #80 was reviewed on 2/18/13 at 10:22 a.m. The resident had diagnoses that included, but were not limited to, Alzheimer's disease. The admission Minimum Data Set (MDS) dated 1/21/13, indicated the resident was severely cognitively impaired. It indicated the resident was totally dependent on staff for			

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	transfers, dressing and bathing. Interview with CNA #1 on 2/18/13 at 1:32 p.m., indicated she was the CNA who transferred the resident out of bed on that day. She indicated the resident had very few clothes. She indicated there were no pants in her room to dress her with, so she dressed her in a hospital gown. Observation of the resident's closet, at that time, with CNA #1, indicated the resident had one lavender sweatshirt in her closet. There were no other articles of clothing in her room. Interview with the Social Service Director on 2/18/13 at 2:33 p.m., indicated she was not aware the resident did not have ample clothing in her room. She indicated the residents were to be dressed in street clothes and not in hospital gowns. She indicated the resident was non-verbal and could not voice her preferences. She indicated the resident's family member had not requested a preference that the resident to be dressed in hospital gowns. On 2/19/13 at 9:01 a.m., interview with the Social Service Director, indicated the resident's clothing had			

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	been found in the facility laundry on 2/18/13. She indicated the resident's clothing had not been marked with the resident's name, so the laundry staff were unable to return the clothing to the resident's room. 3. On 2/13/13 at 10:09 a.m., Resident #48's catheter bag was observed hanging from the side of the bed without a dignity bag. On 2/14/13 at 10:30 a.m., Resident #48's catheter bag was observed hanging from the side of the bed without a dignity bag. On 2/15/13 at 9:00 a.m., Resident #48's catheter bag was observed hanging from the side of the bed without a dignity bag. Resident #48's record was reviewed on 2/18/13 at 8:08 a.m. Resident #48's diagnoses included, but were not limited to, decubitus ulcer (wound), anemia, diabetes, gastrostomy tube (feeding tube), and colostomy. A physician order dated 12/17/12, indicated to ensure the catheter bag was covered. There was a care plan dated 8/24/12,			

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

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	for the resident's catheter care. One of the interventions indicated to keep the catheter bag covered. An interview with the Wound Nurse on 2/19/13 at 3:05 p.m., indicated catheter bags were to be placed in a dignity bag at all times. 3.1-3(t)			

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F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on record review and interview, the facility failed to ensure each resident's choice was honored related to frequency of showers and staff gender providing showers for 2 of 3 residents reviewed for choices of the 3 residents who met the criteria for choices. (Residents #7 and #80) Findings include: 1. A telephone interview with Resident #80's family member on 2/12/13 at 7:13 p.m., indicated the resident's past preference for showering was to receive a shower every other day. She indicated the resident now receives a shower two times per week. The record for Resident #80 was reviewed on 2/18/13 at 10:22 a.m. The resident had diagnoses that included, but were not limited to, Alzheimer's disease.	F000242	**F-Tag 242: Self Determination-Right to Make Choices** It is the policy of Miller's Merry Manor, Hobart for residents to make choices about aspects of his or her life in the facility that are significant to the resident. Resident # 7: Resident preference for staff gender that provide bath/showers, frequency of shower/bath, type of shower/bath and time/day has been added to plan of care. Care will be delivered as indicated on plan of care. Resident # 80: Resident preference related to frequency of showers has been added to the plan of care and facility will deliver care per plan. The social service director or other designee will complete resident choice interviews by 3/22/13 with interviewable residents utilizing the QIS worksheet "Resident Interview/Resident Observation" choices section of worksheet. The QIS worksheet "Family Interview" choices section of worksheet will be completed by 3/22/13 with residents	03/22/2013

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	The admission Minimum Data Set (MDS) dated 1/21/13, indicated the resident was severely cognitively impaired. It indicated the resident was totally dependent on staff for transfers, dressing and bathing. There was a care plan dated 1/22/13 that indicated, "Preferences: Family expresses, during the assessment process, that it is was important for (Resident #80's name) to choose between shower, tub, bed, or sponge bath and to have family/ friend involved in discussions re: care. Interventions: -determine resident's preference for bathing -invite to family/friend to care meeting and encourage attendance." Interview with the Social Service Director on 2/19/13 at 8:46 a.m., indicated the resident could not verbalize her preferences to the staff. She indicated the resident's preferences, as stated by the daughter, indicated the resident preferred to have showers. She indicated she had a list of resident preferences for bathing that then gets relayed to the nursing staff. She indicated she had not asked families and residents how frequently they preferred to be bathed. She indicated		responsible party for those residents who can not be interviewed. Each residents HCP will be individualized to ensure that plan of care is developed complying with residents preferences/choices for care. All new admissions or responsible party will be interviewed regarding resident preferences/choices to ensure plan of care is developed incorporating resident preference and choice. An all staff in-service will be held on or before 3/22/13 to review resident rights with special emphasis on “Choice, Privacy, and Dignity” to ensure staff deliver care per preference and as indicated in individuals plan of care. The nurse aide assignment sheet is used as the communication tool to share pertinent resident preferences for care to the staff delivering the care. Nurse managers, social service designee, and charge nurses will be responsible to make routine walking rounds on units at varying times to monitor that care is delivered per resident preference. The social services director or other designee will be responsible to perform "Resident Satisfaction Questionnaire" (Attachment D) weekly with 3 residents for the next 4 weeks then monthly with 3 residents to monitor for ongoing compliance and satisfaction. Any issues identified will be corrected and logged on facility tracking QA log. The QA tracking log is	

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	she was unaware of the resident's preference for shower frequency. Interview with LPN #2 on 2/19/13 at 9:13 a.m., indicated the resident's preference for bathing was listed on the CNA pocket sheets (written care instructions). Review of the CNA pocket sheet for Resident #80, dated January 23, 2013, indicated the resident was to receive showers on Tuesday and Fridays, two times per week. It did not indicate showers every other day. 2. Interview with Resident #7 on 2/13/13 at 10:12 a.m., indicated the staff would only give her a bed bath. The resident indicated she did not get to choose if she wanted to take a shower or a bath. Resident #7 indicated the staff wouldn't let her pick her shower days or give her a shower when she was ready for one. The resident indicated she would want a bed bath over a shower if the shower room was too cold. The resident indicated she can't remember the last time she received a shower. An interview with Resident #7 on 2/14/13 at 10:20 a.m., indicated her shower days were normally		reviewed monthly in the facility QA meeting to ensure ongoing compliance.	

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	scheduled on Monday and Thursday in the evenings. The resident indicated it wasn't proper for a "young man" to be giving her a shower, only a woman. Resident #7 indicated should would like the shower room to be warm/heated so she can take a shower. Resident #7's record was reviewed on 2/14/13 at 11:30 a.m. Resident #7's diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, anxiety, and vascular dementia. A care plan for preferences was initiated on 6/5/12. The care plan indicated choosing between a shower, tub, bed, or sponge bath was important to the resident. A care plan for ineffective coping was initiated on 8/3/11 and revised on 12/21/12. The interventions initiated on 8/3/11 indicated to try to accommodate the resident's choice of caregiver and praise/reward resident for allowing staff member not of her choosing to provide care. Interview with the SSD (Social Service Designee) on 2/18/13 at 12:40 p.m., indicated she assists the residents with preferences. SSD			

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	indicated she was not aware of the resident having a problem with male caregivers giving her a shower but she would "go back and forth" on who was or wasn't doing a good job with her care. SSD indicated she was not aware of the resident not receiving her showers. 3.1-3(u)(1) 3.1-3(u)(3)			

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F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.			
	Based on observation, record review and interview, the facility failed to ensure each resident received activities designed to meet their preferences related to the lack of assisting a dependent resident to participate in music and spiritual activities for 1 of 1 resident reviewed for activities of the 1 resident who met the criteria for activities. (Resident #80) Findings include: Resident #80 was observed on 2/12/13 at 1:10 p.m. She was seated in a gerichair in her room. There was no radio, tape player or CD player in use. The resident was observed in a gerichair in her room on 2/13/13 at 9:48 a.m., there was no music being played in the room. The resident was observed on 2/14/13 at 10:53 a.m. She was seated	F000248	**F-Tag 248: Activities Meet Interest/Needs of Each Resident** It is the policy of Miller's Merry Manor, Hobart to provide for an ongoing program of activities designed to meet in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. Resident #80: Radio/CD player was put in resident's room and music of resident's preference provided and turned on by staff. Resident routinely attends spiritual activities. All residents are at risk to be affected by the deficient practice. The activity director completed an audit of all resident HCP and preferences to ensure needs are being met for all residents related to activities on 3/4/13. Each resident receives an activity review assessment upon admission, quarterly and prn with any significant changes which reviews each residents preferences. The activity director will in-service the activity department staff by 3/22/13 to review resident preference and implementing the plan of care.	03/22/2013

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	in a gerichair recliner in her room. Review of the activity calendar that was posted in the resident's room indicated that there was an activity scheduled at 11:00 a.m. in the Main Dining Room. The activity was called the "Daily Bread." The resident was observed in her room on 2/14/13 at 11:15 a.m. Continued observations of the resident on 2/18/13 at 10:43 a.m. and at 1:26 p.m., indicated the resident remained in her room and no music was played. On 2/19/13 at 11:10 a.m., the resident was observed in a gerichair in her room, the TV was on, there was no music in the room. The "Daily Bread" activity was being held in the main dining room. Interview with the Activity Director on 2/19/13 at 12:53 p.m., indicated the "Daily Bread" activity was a very popular and well attended activity. She indicated it was a faith based activity with spiritual readings. She indicated it was held 5 days per week, Monday through Friday at 11:00 a.m. The record for Resident #80 was reviewed on 2/18/13 at 10:22 a.m. The resident had diagnoses that		The Activity Director or other designee will complete the QA tool "Activity Participation" (Attachment H) weekly for four weeks on 10 residents and then monthly thereafter to ensure ongoing compliance. Any identified issues will be corrected upon discovery and logged on facility QA tracking log. QA tracking logs are reviewed in the facility monthly QA meeting to monitor for continued compliance.	

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	included, but were not limited to, Alzheimer's disease. The admission Minimum Data Set (MDS) dated 1/21/13, indicated the resident was severely cognitively impaired. It indicated the resident was totally dependent on staff for transfers and locomotion. It also indicated it was very important to the resident to listen to music that she liked, very important to do her favorite activities and very important to participate in religious services or practices. There was a care plan, dated 2/12/13, that indicated, "resident would benefit from increased socialization/stimulation through activities involvement due to: does not initiate activity." Some of the interventions included: "Family Member states listening to music is important to them. Resident enjoys Rick Springfield music (avid fan.) Remind and encourage attendance to musical programs Provide musical tapes for individual listening if resident desires Encourage family to bring in radio/tape player for resident to keep in room. Resident states that it is important to participate in religious services or			

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	practices. Resident enjoys these religious activities, Church services. Resident is of Lutheran faith. " Interview with the Activity Director on 2/19/13 at 12:53 p.m., indicated when she assessed the resident for her activity preferences, the resident was not able to verbalize her preferences, she indicated she obtained the resident's activity preferences from the residents daughter. She indicated the resident's daughter indicated the resident's activity preferences included, music, especially Rick Springfield, cards/solitaire and religious activities. Review of the facility activity calendar for February 2013, indicated "Daily Bread" occurred in the facility each Monday through Friday at 11:00 a.m. There were religious activities "Church Service" on 2/16/13 and Worship Hour on 2/17/13. There were musical activities held on 2/11/13 and 2/18/13. Interview with the Activity Director on 2/19/13 at 12:53 p.m., indicated the activity staff document the activities the residents attend in the computer on the "Point of Care" log. Review of the resident's activity			

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	attendance log indicated the resident had not attended the Daily Bread activity on 2/11, 2/12, 2/13, 2/14, 2/15, 2/18 and 2/19, 2013. She did not attend the musical activities held on 2/11/13 and 2/18/13. She did not attend the religious activities "Church Service" on 2/16/13 and Worship Hour on 2/17/13. Interview with the Activity Director on 2/19/13 at 1:20 p.m., indicated the resident had not attended the out of room activities that were held on 2/11/13 through 2/19/13. Continued interview with the Activity Director, on 2/19/13 at 1:20 p.m., indicated the resident was totally dependent on staff and required staff to take her to the activities. She also indicated the facility had a CD player and could have provided music for the resident in her room, according to her preferences. Observation of the resident's room on 2/19/13 at 1:25 p.m., with the Activity Director, indicated there was no device in the resident's room to play music. 3.1-33(a)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F000278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review and interviews, the facility failed to ensure each resident's comprehensive assessment related to the Minimum Data Set (MDS) assessments were accurate related to fractures, hospice, transfers, and medications for 5 of 28 residents reviewed for accuracy of the	F000278	**F-Tag 278 Assessment Accuracy/Coordination/Certified** It is the policy of Miller's Merry Manor, Hobart to ensure the assessment accurately reflect the residents status. Resident # 19, # 61, #118, #148, and #151: Comprehensive MDS assessments have been corrected for accuracy and	03/22/2013

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	MDS assessments. (Resident's #19, #61, #118, #148, and #151) Findings include: 1. The record for Resident #19 was reviewed on 2/14/13 at 6:09 a.m. Review of Physician Orders dated 1/19/13, indicated the resident was admitted to Hospice. Review of the significant change Minimum Data Set (MDS) assessment dated 1/25/13, indicated the resident was receiving hospice care. Under the section regarding "does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months" the MDS was coded "no". Interview with MDS Coordinator #2 on 2/14/13 at 9:45 a.m., indicated she inaccurately coded the prognosis section for less than 6 months to live, because she did not have the signed certification from the physician indicating so. Further interview on 2/14/13 at 11:00 a.m., indicated that she had called Hospice and they were faxing over the certification paper indicating the resident's prognosis.		resubmitted by 3/22/13. *All residents are at risk to be affected by the deficient practice.* The most recent MDS for active residents will be reviewed by the nurse management team for accuracy of coding for fractures, hospice, transfers, antidepressant medication, and anticoagulant medications and corrections submitted to ensure accuracy by 3/22/13. A registered nurse will continue to coordinate each assessment with the participation of the health care plan team. Assessments will be completed accurately to reflect the resident's status. The RAI manual definition for coding of fractures, hospice, transfers, antidepressant medication, and anticoagulant medication was reviewed by the MDS coordinators on 3/7/13 to ensure that coding of these areas is completed accurately. The MDS coordinator or other designee will be responsible to complete the QA tool "MDS Accuracy Review"(Attachment E) on each MDS assessment completed thru 3/31/13, then on a random sample of 10 charts monthly to ensure continued compliance. Any identified inaccuracy will be corrected and logged on facility QA tracking log. QA tracking logs are reviewed in the facility monthly QA meeting to monitor for continued compliance.	

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	2. The record for Resident #118 was reviewed on 2/18/13 at 9:04 a.m. The resident was admitted to facility on 9/21/13 from the hospital. Review of the admission Minimum Data Set (MDS) assessment dated 9/28/12, indicated the resident had limited assist with one person physical assist for transfer ability in her Activities of Daily Living (ADL). Review of the 9/22/12 "ADL Legend", completed by CNA staff for transfers indicated the resident was coded as needing total dependence for transfers nine times out of 15 opportunities over seven days during the assessment reference period for the admission MDS completed on 9/28/12. Interview with Physical Therapist #1 on 2/18/13 at 1:44 p.m., indicated the resident was a hoyer lift for transfer and was totally dependent on staff for transfers at the beginning of therapy which began on 9/24/12. Interview with MDS Coordinator #2 on 2/8/13 at 10:17 a.m. indicated the resident's transfer status was inaccurately coded on the admission assessment. She further indicated the transfer status should have been			

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	coded as extensive assist with a two person physical assist. 3. The record for Resident #61 was reviewed on 2/14/13 at 10:43 a.m. Review of Physician Orders on the current 2/13 recap with an original date of 9/10/10, indicated the resident was receiving Lexapro (an antidepressant) 10 milligrams (mg) everyday. Another Physician's Order dated 9/7/11, indicated the resident was to receive an additional 5 mg of Lexapro to equal 15 mg daily. Review of the 1/13 and 2/13 Medication Administration Record (MAR) indicated the Lexapro medication was signed out as being given 1/1-1/31/13 and 2/1-2/13/13. Review of the quarterly Minimum Data Set (MDS) assessment dated 1/15/13, indicated a zero was coded for the number of days the resident was receiving an antidepressant medication. Interview with MDS Coordinator #2 on 2/18/13 at 3:00 p.m., indicated the Lexapro (the antidepressant medication) was not coded accurately on the quarterly MDS in 1/13.			

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	4. The record for Resident #151 was reviewed on 2/18/13 at 8:48 a.m. The resident had diagnoses that included, but were not limited to, atrial fibrillation (an irregular heart rhythm). There was a Physician Order dated 1/28/13, that indicated the resident was to receive Coumadin (an anticoagulant, blood thinning medication) 2 mg (milligrams) 1 tab by mouth daily at 5 p.m. for atrial fibrillation. The admission Minimum Data Set (MDS) assessment with the ARD (Assessment Reference Date) of 2/4/13, was reviewed. The section that indicated the number of days in the past 7 days that the resident received anticoagulant medication was coded, "0 (zero) days." Review of the January 2013 Medication Administration Record (MAR), indicated Coumadin was administered to the resident on 1/28/13, 1/29/13, 1/30/13 and 1/31/13. Review of the February 2013 MAR, indicated Coumadin was administered to the resident on 2/1/13, 2/2/13, 2/3/13, 2/4/13.			

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	Interview with MDS Coordinator #2 on 2/18/13 at 9:20 a.m., indicated the MDS was not accurately coded for the use of anticoagulant medications. 5. Resident #148 was observed on 2/14/13 at 9:01 a.m., she was seated in a wheelchair. Her right ankle was wrapped with an elastic bandage and was elevated on the foot rest. The record for Resident #148 was reviewed on 2/14/13 at 11:23 a.m. She was admitted to the facility on 1/31/13. She had diagnoses that included, but were not limited to, fracture of right ankle. There was a History and Physical dated 1/27/13, that indicated, "Chief complaint: Fall: . . . Upon arrival at the ED (Emergency Department) the pt's (patient's) bp (blood pressure) was in the 90's systolic. X-ray showed trimaleolar (bone in the ankle) fracture and reduction was obtained with ortho's (orthopedic's) help." The admission Minimum Data Set (MDS) assessment dated 2/7/13, was reviewed. The section that indicated, "Did the resident have any fracture due to a fall in last 2-6 months prior to admission?" was coded "no."			

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	The Nursing-Admission/Return assessment dated 1/31/13, indicated the reason for admit/return to nursing facility was, "rehab/patient was getting up to go to the bathroom fell breaking ankle-splint ace wrapped ORIF (open reduction internal fixation, a surgical repair) right trimaleolar ankle fracture . . ." Interview with MDS Coordinator #2 on 2/14/13 at 1:45 p.m., indicated the MDS was inaccurately coded for fractures. 3.1-31(d)			

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F000280 SS=A	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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. Based on observations, record review and interview, the facility failed to revise care plans to reflect the resident's current status related to nutritional status and interventions to reduce falls for 3 of 28 residents reviewed for care plans. (Resident #26, #48 and #80) Findings include: 1. The record for Resident #80 was reviewed on 2/18/13 at 10:22 a.m. The resident had diagnoses that included, but were not limited to, gastrostomy tube (a tube inserted through the abdominal wall for the	F000280	**F-Tag 280 Comprehensive Care Plan:** It is the policy of Miller's Merry Manor, Hobart that each 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 changes in care and treatment. The health care plans for resident # 26, #48, and #80 have all been reviewed and updated by all members of the health care plan team to accurately reflect the resident's status. *All residents are at risk to be affected by the deficient practice.* All residents in-house will have a complete review of current care plans for	03/22/2013

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	delivery of fluids and nutrition) and Alzheimer's disease. The admission Minimum Data Set (MDS) assessment dated 1/21/13, indicated the resident had a feeding tube. Interview with the Director of Nursing on on 2/18/13 at 1:24 p.m., indicated the resident was NPO (no fluids or nutrition by mouth). There was a care plan initiated on 1/15/13, that indicated, "Potential for skin breakdown. At risk due to decreased bed mobility." Interventions included: "Assess food likes and dislikes. Encourage meal/fluid intake and record. Offer two entree selections every meal. In addition, use the always available alternate list as needed. Provide 4 oz (ounce) vitamin C enriched juice daily. Provide a nourishing hs (hour of sleep) snack." The care plan did not reflect the resident's current status of no oral nutrition. Interview with MDS Coordinator #1 on 2/19/13 at 9:50 a.m., indicated the		Nutritional Risk and Fall Risk completed by 3/22/13 to ensure all interventions are in place as indicated on plan of care.. Any orders received on daily basis are updated to the care plan by the receiving nurse at the time of the order and monitored by the nurse management team. All licensed nurses, and other department directors who participate in the care planning process will be in-serviced by 3/22/13. The in-service will be to discuss the process for developing, revising, and ensuring the plan of care accurately reflects the residents status. The MDS coordinator or other designee will be responsible to complete the QA tool titled " Care Plan Review"(Attachment F) on 10% of all HCP reviewed each month for the next 6 months, then a minimum of 5 HCP monthly thereafter to monitor for ongoing accuracy and compliance. Any issues will be corrected upon discovery then logged on QA tracking tool. QA tracking tools are reviewed during the monthly facility QA meeting for ongoing compliance.	

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	care plan was not reflective of the resident's status. 2. On 2/12/13 at 12:34 p.m., Resident #48's bed was observed. The bed had an air mattress with built in bolsters, the bed was not a low bed. Resident #48's record was reviewed on 2/18/13 at 8:08 a.m. Resident #48's diagnoses included, but were not limited to, decubitus ulcer (wound), anemia, diabetes, gastrostomy tube (feeding tube), and colostomy. A fall risk care plan initiated on 8/24/12, was reviewed. The interventions indicated (12/19/12) low bed with low air loss perimeter (bolsters) mattress to be used, (12/10/12) provide a low bed, (1/22/13) order for low air loss mattress to the bed. An interview with the Wound Nurse on 2/18/13 at 2:44 p.m., indicated she had observed the resident's bed at that time. She indicated the resident did not have a low bed. She indicated the resident's daughter didn't want the resident on a low bed so it was changed to the current frame on			

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	December 10, 2012. She indicated the care plan did not reflect the resident's current status. 3. Resident #26's record was reviewed on 2/14/13 at 10:46 a.m. Resident #26's diagnoses included, but were not limited to, hypertension, anxiety, gastrointestinal (stomach) discomfort, atrial fibrillation (irregular heart rhythm), neuropathic pain, chronic respiratory disease and depression. A care plan for nutritional risk was initiated on 4/26/12 and revised on 11/7/12 related to a weight loss of 3.6%. An intervention dated 8/14/12, indicated the resident was to receive a 4 oz (ounce) house supplement at breakfast, monitor intakes, and on 11/7/12, weekly weights were initiated. The December 2012 and January 2013 Physician Recapitulation orders indicated the resident was to receive health shakes with each meal. Interview with the Director of Nursing at 1:00 p.m. on 2/19/13, indicated the health shakes were discontinued at the beginning of February. The resident's care plan was not			

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	revised to reflect the resident's current status related to supplements. 3.1-35(d)(2)(B)			

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F000282 SS=E	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, record review, and interviews, the facility failed to follow Physician Orders and/or the resident's plan of care related to Activities of Daily Living (ADL) for oral care for 1 of 3 residents reviewed for ADL care of the 9 residents who met the criteria for ADL care, related to pain management for 3 of 3 residents reviewed for pain management of 4 residents who met the criteria for pain, related to nutrition for weekly weights for 1 of 3 residents reviewed for nutrition of the 8 residents who met the criteria for nutrition, and related to unnecessary medications for 2 of 10 residents reviewed for unnecessary medication. (Resident's #19, #26, #58, #87, and #151) Findings include: 1. On 2/12/13 at 10:53 a.m., Resident #19 was observed in bed. At that time, the resident was noted with food in her teeth and her lips were dry. On 2/14/13 at 6:00 a.m., the resident	F000282	**F-Tag 282 Services by Qualified Persons/Per Care Plan:** It is the policy of Miller's Merry Manor, Hobart that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care related to oral care, residents weight, pain management, insulin coverage, and antibiotic therapy. **Resident # 19**: Physicians order for oral care was reviewed and will be delivered as indicated by individuals plan of care.**Resident #26**: HCP intervention for weekly weights has been discontinued. Pain level will continue to be assessed per facility policy. Policy for pain does not require pre/post pain assessment for routine pain management. Nursing will monitor for s/s of break thru pain daily. Prior to administration of any PRN pain medication pre and post assessment will be completed using a 1-10 scale to evaluate effectiveness.**Resident # 58**: has been discharged from facility **Resident #87**: Multiple wheelchair options/ and alternate seating cushions have been trialed with resident to improve	03/22/2013

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	was observed in bed. At that time, her lips had dried skin noted to them. On 2/14/13 at 10:24 a.m., the resident was sitting up in a broda chair. The resident was observed to have food in her bottom teeth. On 2/18/13 at 8:30 a.m., the resident was in bed. The resident's lips were dry. On 2/18/13 at 10:03 a.m., the resident was in bed. The resident's lips were dry and she had food in her bottom teeth by her gums. On 2/19/13 at 8:24 a.m., the resident was in bed. The resident had food in her bottom teeth by her gums. On 2/19/13 at 10:20 a.m., CNA #2 indicated she had tried to brush the resident's teeth earlier, but the resident would not let her. At that time, the CNA was asked again to try and brush the resident's teeth. The resident opened her mouth and allowed the CNA to use a soft toothette with toothpaste on it. The CNA was able to remove the food in the resident's bottom teeth and by her gums. The record for resident #19 was		wheelchair positioning and comfort. Resident has expressed preference to remain in the same wheelchair with same seating cushion that was observed during annual survey. Resident expresses improved pain management with daily am dose of Tramadol. Physician contacted and desires to continue daily Tramadol. Nursing to assess daily for break thru pain and offer prn pain meds as needed. Prior to administration of any PRN pain medication pre and post assessment of pain level will be completed using a 1-10 scale to evaluate effectiveness. On 3/12/13 the facility ordered another type of cushion to trial in wheelchair upon its arrival.**Resident # 151**:has been discharged from facility *All residents are at risk to be affected by the deficient practice.* All resident HCP problems/interventions related to oral care, nutritional risk, pain management, insulin coverage, and ATB treatment for infection will be reviewed on or before 3/22/13 by members of the HCP team. All nursing staff in-service will be completed on or before 3/22/13 to review the process for ensuring weekly weights, oral care, and physicians orders for pain management, insulin coverage, and antibiotics to tx infection, are delivered as ordered or indicated in residents individual HCP. The	

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	reviewed on 2/14/13 at 6:09 a.m., The resident's diagnoses included, but were not limited to Alzheimer's disease, gastrostomy status, senile dementia, rheumatoid arthritis, and depressive disorder. Review of the current 2/12/13 plan of care, indicated the resident was at risk for oral irritation related to having her own teeth in poor condition. The nursing approaches were to provide oral care per staff twice daily and as needed. Review of Physician Orders dated 1/2/13, indicated oral care every shift and as needed per nursing measure. Interview with LPN #4 on 2/19/13 at 10:30 a.m., indicated oral care for the resident should be done at least daily and as needed. She further indicated there was no care plan or documentation the resident refused oral care.		facility pain policy will be reviewed and charge nurses will be instructed to use the prn pain flow sheet to record pre and post pain assessment for prn pain medication use. A scale of 1-10 will be utilized to measure pain level. Residents who are receiving routine pain medications for pain management programs will continue to be assessed weekly with weekly summary assessment, pre and post PRN pain medications, during MDS assessment, and with pertinent significant change in status. The process for ensuring timely initiation of ATB therapy by immediately removing the initial dose of ATB from the facility pyxis machine or if not available in the facility pyxis the charge nurse will be responsible to contact the pharmacy for a STAT delivery. Initiation of ATB therapy will also be documented on 24 hour report tool. A review on properly administering insulin coverage at the correct dose per physicians order will be emphasized. Charge nurses will be responsible to check dose of coverage with another licensed nurse prior to administering for next 30days. Residents with specific interventions on HCP for frequency of oral care and weights will be communicated via the nurse aide assignment sheets to ensure that care is provided as indicated in each individuals	

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			plan. The DON or other designee will be responsible to complete the "MAR/TAR/Weekly Summary Review" (Attachment I) daily x1 week, then 3x weekly x 4 weeks, then weekly x4 weeks, and monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected upon discovery and documented on facility QA tracking log. QA tracking logs are reviewed monthly during the facility QA meeting.The MDS coordinator or other designee will be responsible to complete the QA tool titled “Care Plan Review”(Attachment F) on 10% of all HCP reviewed each month for the next 6 months, then a minimum of 5 HCP monthly thereafter to monitor for ongoing accuracy and compliance. Any issues will be corrected upon discovery then logged on QA tracking tool. QA tracking tools are reviewed during the monthly facility QA meeting for ongoing compliance.	
	2. The record for Resident #151 was reviewed on 2/18/13 at 8:48 a.m. The resident had diagnoses that included, but were not limited to, atrial fibrillation (an irregular heart rhythm) and congestive heart failure. The admission Minimum Data Set (MDS) assessment with the ARD (Assessment Reference Date) of 2/4/13, was reviewed. The section that indicated the number of days in			

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	the past 7 days that the resident received antibiotic medication was coded, "2 days." There was a progress note dated 2/1/13 at 1330 (1:30 p.m.), that indicated a Physician Order was received to send the resident to the Emergency Room to evaluate and treat the resident's swollen left arm and change in her mental status. There was a Physician Order dated 2/1/13, that indicated, "Send to (name of hospital) ER (Emergency Room) for change in mental status." There was a Physician's Order dated 2/1/13, signed by the Emergency Department Physician, that indicated, "Nitrofurantoin (Macrobid) (an antibiotic medication) 100 mg (milligrams) take 1 capsule by mouth 2 times daily for 10 days." The assessment for the return from ER that was electronically signed by RN #2 on 2/2/13, indicated the resident returned from the ER with new orders received for Macrobid 100 mg take one tablet by mouth 2 x day for 10 days. The assessment indicated the resident returned from the ER and "does have a UTI (urinary tract infection)."			

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	Interview with RN #2 on 2/19/13 at 2:49 p.m., indicated she was the nurse in charge when the resident returned from the Emergency Room. She indicated the resident returned from the hospital on 2/1/13 with orders for Macrobid for a UTI. Review of the urine culture report dated 2/1/13, indicated the urine had >100,000 colonies of enteroccoccus (type of bacteria) species sensitive to Nitrofurantoin. Review of the February 2013 MAR, indicated the Macrobid was not initiated until 2/3/13 at 9 a.m., the resident did not receive the antibiotic medication at the facility on 2/1/13 or 2/2/13. Interview with the Nursing Consultant on 2/18/13 at 12:20 p.m., indicated the resident was sent to the ER on 2/1/13. She indicated she had a diagnosis of a urinary tract infection. She also indicated the Physician ordered an antibiotic for the UTI, Macrobid 100 mg. She indicated the medication was available in the facility on 2/1/13 in the PYXIS, a computer generated emergency drug kit. She indicated the medication was not initiated until 2/3/13.			

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	The policy titled "Ordering and Receiving Medications from Pharmacy" that was undated, was provided by the Administrator on 2/18/13 at 1:43 p.m. She indicated the policy was current. The policy indicated: "New medications, except for emergency or "stat (immediate)" medications, are ordered as follows: Timely delivery of new orders is required so that medication administration is not delayed. The PYXIS machine is used when the resident needs a medication prior to delivery. If the needed medication is not available in the PYXIS machine, the pharmacy must be phoned immediately and informed the delivery of the medication is needed within four(4) hours." Interview with the Nursing Consultant on 2/18/13 at 3:18 p.m., indicated there was Macrobid available in the PYXIS on 2/1/13, when the medication was ordered by the Physician. She indicated the resident should have received the antibiotic medication, Macrobid, on 2/1/13 and 2/2/13. 3. Resident #58's record was			

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	reviewed on 02/14/13 at 10:05 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and neuropathy. A) A care plan, dated 10/24/12, indicated the resident had a potential for pain. The interventions included to assess the pain using the 0-10 scale, administer the pain medications as ordered and note the effectiveness, give the as needed pain medication for breakthrough pain and note the effectiveness, and document/report complaints and non-verbal signs of pain. The physician's orders, dated 01/25/13, indicated an order for roxanol (narcotic pain medication), 5 mg (milligrams) sublingually every two hours as needed for pain or shortness of breath. A physician's order, dated 12/28/12, indicated an order for Percocet (narcotic pain medication) 10-325 mg, two tablets every four hours as needed for pain, The Medication Administration Record (MAR), dated 01/13, indicated the resident received the roxanol without documentation to indicate the reason or the effectiveness of the			

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MILLER'S MERRY MANOR	2901 W 37TH AVE HOBART, IN 46342

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	roxanol on the following dates and times: 01/26/13 at 6 a.m. 01/27/13 at 8 a.m., 10 a.m. and 12 p.m. 01/28/13 three times (no times listed) 01/29/13 two times (no times listed) 01/30/13 at 8 a.m. and 10 a.m. The Nursing Progress Notes on the above dates lacked documentation to indicate the reason the roxanol was administered, an assessment of the pain, and the effectiveness of the medication. The MAR, dated 01/13, indicated the resident received the Percocet without an assessment of the pain and an assessment of the effectiveness of the Percocet on the following dates and times: 01/12/13 twice (no time documented) 01/15/13 at 4 p.m. and 8 p.m. 01/15/13 at 4:15 p.m. 01/17/13 at 3:30 p.m. The Nursing Progress notes on the above dates lacked documentation to indicate an assessment was completed for the pain and the effectiveness of the pain medication. A physician's order, dated 01/31/13, indicated an order to change the			

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	roxanol to 5 mg by mouth, every one hour as needed for breakthrough pain or shortness of breath. The MAR, dated 02/13, indicated the resident received the roxanol without documentation to indicate the reason or the effectiveness of the roxanol on the following dates and times: 02/02/13 at 8 a.m., 9 a.m., 10 a.m., 11 a.m., and 12 p.m. 02/03/13 at 12 a.m., 1 a.m., 4 a.m., and 6 a.m. 02/04/13 at 3 p.m., 4 p.m., 5 p.m., 6 p.m., and 7 p.m. 02/05/13 at 6:30 p.m. The Nursing Progress Notes on the above dates lacked documentation to indicate the reason the roxanol was administered, an assessment of the pain, and the effectiveness of the medication. During an interview on 02/14/13 at 11:31 a.m., LPN #3 indicated the resident's pain should have been assessed for intensity and where the pain was, prior to the administration of the medication, then the nurse should have checked for the effectiveness a half hour to an hour after the medication was administered, and the effectiveness should have been documented.			

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	B) Resident #58's Physician's Orders, dated 12/28/12, indicated an order for Novolin regular insulin to be given on a sliding scale after checking the resident's blood sugar four times a day (amount of insulin given by the resident's blood sugar results). The Sliding scale orders included: blood sugars 201-250 give 4 units of insulin blood sugars 251-300 give 6 units of insulin blood sugars 351-400 give 10 units of insulin A care plan, dated 05/08/12 and updated on 11/13/12, indicated the resident was at risk for high or low blood sugars. The interventions included to give insulin as ordered. The 01/13 MAR's indicated the resident's blood sugars were as followed: 01/09/13 at 4 p.m., the blood sugar was 249 and he received 6 units of insulin, 01/14/13 at 4 p.m., the blood sugar was 287 and he received 4 units of insulin 01/16/13 at 11 a.m., the blood sugar was 382 and he received 8 units of insulin			

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	During an interview on 02/14/13 at 11:31 a.m., LPN #3 indicated the resident received the incorrect dose of insulin. Surveyor: Pietraszewski, Shann 4. Resident #26's record was reviewed on 2/14/13 at 10:46 a.m. Resident #26's diagnoses included, but were not limited to, hypertension, anxiety, gastrointestinal discomfort (stomach), atrial fibrillation (irregular heart rhythm), neuropathic pain, respiratory failure and depression. A care plan for nutritional risk was initiated on 4/26/12 and revised on 11/7/12 related to a weight loss of 3.6%. An intervention dated 11/7/12, indicated weekly weights were to be done. The resident weights were completed on 11/7/12, 11/14/12, 11/21/12, 12/3/12, 1/7/13, and 2/5/13. Weekly weights were not completed as indicated in the care plan. A care plan for complaints of gastrointestinal (stomach) discomfort was initiated on 8/17/12. The interventions indicated to administer medications as ordered, monitor for			

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	discomfort, and notify the physician of any abnormal findings. A care plan for chronic pain was initiated on 2/5/13. The goal was for the resident's pain to be controlled at an acceptable level. The interventions indicated to acknowledge the presence of pain and discomfort, monitor for effectiveness of pain medication, and give Norco (pain medication) as ordered. The February 2013 Physician Recapitulation orders indicated on 2/5/13, an order for hydrocodone (pain medication) 5/325 mg (milligrams) was to be given at 6:00 a.m., 2:00 p.m., and 10:00 p.m. for pain management. Review of the February 2013 Medication Administration Record, indicated the pain medication was administered as ordered. The February 2013 MAR (Medication Administration Record) and the Pain Management flow sheet did not indicate a pre/post assessment for pain had been completed when the resident received her scheduled pain medication.			

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	A Pain Management Program Policy dated 11/30/2010, was provided by the MDS (Minimum Data Set) Coordinator on 2/19/13 at 12:15 p.m. The MDS Coordinator indicated the policy was current. The Policy indicated to assess pain by using the 0-10 numeric/picture scale (1 being mild and 10 being worst pain ever). The Policy indicated the location of the pain, level of pain and the medication and dose administered would be documented. Evaluation of the effectiveness would be determined by reassessing level of pain 30 to 60 minutes post medication administration. Interview with the DON on 1:00 p.m. on 2/19/13, indicated the staff should have been assessing the resident's pain with pain medications 5. On 2/12/13 at 11:02 a.m., Resident #87 was observed being restless and leaning to the left side of her w/c (wheelchair). The resident's right hand was between her right hip and the inside of her w/c. The resident indicated she was having discomfort with the padding and had been requesting a new pad but never received a new one.			

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	An interview with RN #1 on 2/12/13 at 11:30 a.m., indicated she was not aware of the resident's discomfort in her w/c. On 2/14/13 at 10:37 a.m., Resident #87 indicated she needed a better pad in her w/c. She had indicated she had not told anyone about the discomfort she had in her w/c at that time. The resident continued to be leaning to her left side and having her hand placed between her right hip and the w/c. An interview with LPN #3 on 2/14/13 at 11:00 a.m., indicated she was not aware of the resident's need for a different seat cushion or complaints of pain. An interview with SSD (Social Service Designee) on 2/18/13 at 12:40 p.m., indicated she was not aware of the residents pain or problems with the cushion. Resident #87's record was reviewed on 2/19/13 at 9:30 a.m. Resident #87's diagnoses included, but were not limited to, paraplegia, diabetes mellitus, obesity and polyarthritis. A nursing note dated 1/22/13 at 7:07 a.m., indicated the resident had been			

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	asking for tramadol (pain medication) every morning after breakfast. There had been no nursing documentation regarding pain since 11/25/12. An order for Tramadol 37.5/325 mg to be given at 8:00 a.m. was obtained. A care plan for pain was initiated on 3/10/11 and was revised on 1/29/12 with interventions indicating to assess pain using the 0-10 scale, monitor the effectiveness of pain medications, administer pain medication as per physician orders and note the effectiveness, and acknowledge presence of pain and discomfort. The January and February 2013 MARs were reviewed. The resident received scheduled pain medication in January and in February, 2013. The January and February 2013 MARs and Pain Management flow sheet did not indicate a pre/post assessment for pain had been completed when the resident received her scheduled pain medication. A Pain Management Program Policy dated 11/30/2010, was provided by the MDS (Minimum Data Set) Coordinator on 2/19/13 at 12:15 p.m. The MDS Coordinator indicated the policy was current. The Policy			

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	indicated to assess pain by using the 0-10 numeric/picture scale (1 being mild and 10 being worst pain ever). The Policy indicated the location of the pain, level of pain and the medication and dose administered would be documented. Evaluation of the effectiveness would be determined by reassessing level of pain 30 to 60 minutes post medication administration. An interview with the DON on 1:00 p.m. on 2/19/13, indicated the staff should have been assessing the resident's pain with pain medications. 3.1-35(g)(2)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interviews, the facility failed to ensure each resident who was dependent on staff for Activities of Daily Living (ADL) care received the necessary treatment and services related to oral care and showers for 2 of 3 residents reviewed for ADL care of the 9 residents who met the criteria for ADL care. (Resident's #19 and #7) Findings include: 1. On 2/12/13 at 10:53 a.m., Resident #19 was observed in bed. At that time, the resident was noted with food in her teeth and her lips were dry. On 2/14/13 at 6:00 a.m., the resident was observed in bed. At that time, her lips had dried skin noted to them. On 2/14/13 at 10:24 a.m., the resident was sitting up in a broda chair. The resident was observed to	F000312	F-Tag 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS:It is the policy of Miller's Merry Manor, Hobart to ensure that a resident who is unable to carry our activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.Resident # 19: Oral care will be provided by qualified individual each shift and as needed to meet oral hygiene needs.Resident # 7: Resident will be interviewed and pertinent preferences related to bathing schedule, frequency, and type will be updated in plan of care by 3/22/13. All residents are at risk to be affected by the deficient practice.HCP's related to oral care and ADL care will be reviewed by 3/22/13. Any preferences identified by interviews completed for F-Tag 242 regarding resident choice will also be updated and included in reviewed plan of care by 3/22/13. All nursing staff in-serviced by 3/22/13 regarding delivery of care for dependent residents with emphasis on grooming, and personal/oral hygiene needs. The nursing assignment sheets	03/22/2013

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	have food in her bottom teeth. On 2/18/13 at 8:30 a.m., the resident was in bed. The resident's lips were dry. On 2/18/13 at 10:03 a.m., the resident was in bed. The resident's lips were dry and she had food in her bottom teeth by her gums. On 2/19/13 at 8:24 a.m., the resident was in bed. The resident had food in her bottom teeth by her gums. On 2/19/13 at 10:20 a.m., CNA #2 indicated she had tried to brush the resident's teeth earlier, but the resident would not let her. At that time, the CNA was asked again to try and brush the resident's teeth. The resident opened her mouth and allowed the CNA to use a soft toothette with toothpaste on it. The CNA was able to remove the food in the resident's bottom teeth and by her gums. The record for resident #19 was reviewed on 2/14/13 at 6:09 a.m., The resident's diagnoses included, but were not limited to Alzheimer's disease, gastrostomy status, senile dementia, rheumatoid arthritis, and depressive disorder.		will serve as a communication tool to identify care needs of residents, resident preferences, and interventions to meet the individuals plan of care. Charge nurses will be responsible to make walking rounds of unit during tour of duty to monitor that care is being delivered to the residents as indicated in plan of care. The corrective action will be monitored utilizing the QA tool "Quality Care Review" (Attachment C). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.	

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	Review of the significant change Minimum Data Set (MDS) assessment dated 1/25/13 indicated the resident was not alert and oriented. The resident was coded as having no behaviors or refusal of care. The resident was totally dependent on staff with one person physical assist with dressing, personal hygiene, and bathing Review of the current 2/12/13 plan of care, indicated the resident was at risk for oral irritation related to having her own teeth in poor condition. The nursing approaches were to provide oral care per staff twice daily and as needed. Review of Physician Orders dated 1/2/13, indicated oral care every shift and as needed per nursing measure. Interview with LPN #4 on 2/19/13 at 10:30 a.m., indicated oral care for the resident should be done at least daily and as needed. She further indicated there was no care plan or documentation the resident refused oral care. 2. An interview with Resident #7 on 2/13/13 at 10:12 a.m., indicated the			

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	staff would only give her a bed bath. The resident indicated she did not get to choose if she wanted to take a shower or a bath. Resident #7 indicated the staff wouldn't give her a shower when she was ready for one. The resident indicated she would want a bed bath over a shower if the shower room was too cold. The resident indicated she can't remember the last time she received a shower. An interview with Resident #7 on 2/14/13 at 10:20 a.m., indicated her shower days were normally scheduled on Monday and Thursday in the evenings. Resident #7's record was reviewed on 2/14/13 at 11:30 a.m. Resident #7's diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, anxiety, and vascular dementia. Showers were documented on Shower/Skin sheets and on Shower/Bath ADL(activities of daily living) records. Review of the Shower/Skin sheets of the last 90 days, indicated showers were given on 2/14/13, 2/11/13, 2/4/13, 1/24/13, 1/17/13, 1/14/13,			

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	1/10/13, 12/6/12 and 12/2/12. Bed baths were given on 1/12/13, 1/7/13, 1/3/13, 12/25/12, 12/19/12, and 12/16/12. Review of the Shower/Bath ADL records, in the computer, of the last 90 days, indicated full bed baths were given on 2/14/13, 2/11/13, 2/4/13, 1/27/13, 1/24/13, 1/17/13, 1/14/13, 1/7/13, 1/3/13, 12/30/12, 12/29/12, 12/28/12, 12/25/12, 12/24/12, 12/20/12, and 12/6/12. The Shower/Bath ADL's indicated showers were given on 2/7/13, 2/1/13, 1/28/13, 1/21/13, 1/11/13, 12/31/12, 12/17/12, 12/10/12, and 12/3/12. Interview with the SSD (Social Service Designee) on 2/18/13 at 12:40 p.m., indicated she was not aware of the resident not receiving her showers. An interview with CNA #4 on 2/19/13 at 10:10 a.m., indicated the CNAs would notify the nurse if the resident refused a shower and document the refusal on the shower/skin sheets. If a resident preferred a bed bath, the bath would have been documented on the shower/skin sheets, otherwise a shower was given. CNA #4 also indicated the nurses sign off on the sheets due to skin assessments. The			

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	CNAs also document in the computer by shift if a.m./p.m. care was done, full bed bath, shower, or if a shower was refused. 3.1-38(a)(3)(C) 3.1-38(b)(2)			

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F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident with an indwelling Foley catheter received the necessary treatment and services to prevent infection related to keeping the drainage bag and/or tubing off of the floor for 1 of 1 residents reviewed for Foley catheters. The facility also failed to promptly provide the antibiotic treatment for a resident with a urinary tract infection, for 1 of 10 residents reviewed for unnecessary medications. (Resident #19 and Resident #151) Findings include: 1. On 2/12/13 at 10:54 a.m. and 2:00 p.m., Resident #19 was observed in bed. At those times the resident's urinary catheter drainage bag was uncovered and laying on the floor.	F000315	**F-Tag 315 No Catheter, Prevent UTI, Restore Bladder:** It is the policy of Miller's Merry Manor Hobart to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident # 151: has been discharged from the facility Resident # 19 : Foley catheter will be maintained per policy. All residents are at risk to be affected by the deficient practice. The nurse managers will complete a chart audit for all residents to ensure that foley catheter care and antibiotic for UTI are in place per policy and that other residents have not been affected by the deficient	03/22/2013

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	On 2/13/12 at 8:45 a.m., the resident was observed in bed. The Foley catheter drainage bag was uncovered and laying on the floor. On 2/14/13 at 6:00 a.m., 7:20 a.m., and 9:15 a.m., the resident was observed in bed. The Foley catheter drainage bag was uncovered and it was laying on the floor. The tubing was also noted to be on the floor. On 2/18/13 at 8:30 a.m., and 10:03 a.m., the resident was observed in bed. At that time the Foley drainage bag was observed in a dignity bag, however, the catheter tubing was observed on the floor. On 2/19/13 at 8:24 a.m., the resident was observed in bed. The resident's Foley catheter drainage bag as well as the catheter tubing was observed on the floor. Interview with CNA #2 on 2/19/13 at 10:20 a.m., indicated she was aware the Foley catheter drainage bag and tubing were not to be on the floor. The record for Resident #19 was reviewed on 2/14/13 at 6:09 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's		practice by 3/22/13.All nursing staff will be in-serviced on or before 3/22/13 to review the facility policy for catheter care, the importance of maintaining infection control practices related to catheter care and antibiotic treatment ordered by physician for UTI. The importance of keeping the urinary drainage bag below the level of the bladder and making sure that the catheter tubing never touches the floor to reduce risk for infection. Charge nurses will be instructed to complete the Outpatient return assessment in the EMR following any resident return from ER evaluation. The assessment includes area for description of any new medications ie: ATB. Charge nurse will be educated to obtain the initial dose from the facility emergency pyxis and if not available that the pharmacy be notified of need for stat delivery to ensure prompt initiation of new ATB medications. The initiation of ATB will also be documented on the 24 hour report sheet to be used as a tool to communicate from one shift to the next shift. The nurse managers routinely review the 24hour condition report in the EMR daily for significant changes in status and to monitor that new antibiotic orders are initiated. All charge nurses will be responsible to make random walking rounds on unit assigned and to monitor for proper catheter maintenance to	

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	disease, and open wound to the buttock. Review of the significant change Minimum Data Set (MDS) assessment dated 1/25/13, indicated the resident was not alert and oriented and had no behaviors. The resident was totally dependent on staff with one person physical assist with bed mobility, transfers, dressing, eating, personal hygiene, locomotion on and off unit, and bathing. The resident had an indwelling Foley catheter. Review of Physician Orders dated 1/2/13, indicated catheter: ensure the catheter bag was below the waist, and covered and tubing was not touching the floor. Interview with LPN #4 on 2/19/13 at 10:30 a.m., indicated the Foley catheter drainage bags and tubing should not be on the floor. 2. The record for Resident #151 was reviewed on 2/18/13 at 8:48 a.m. The resident had diagnoses that included, but were not limited to, atrial fibrillation (an irregular heart rhythm) and congestive heart failure.		reduce risk for infection. The TAR will be signed off each shift by charge nurse reflecting that catheter care is provided and that urinary drainage bag and tubing is maintained per policy. The DON or other designee will be responsible to complete the QA tool titled “24 Hour Condition Review” (Attachment B) daily x 1week, then bi-weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected and logged on facility QA tracking log. The QA tracking logs are reviewed during the facility monthly QA meeting to ensure ongoing compliance. The corrective action will be monitored utilizing the QA tool “Quality Care Review” (Attachment C). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.	

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	The admission Minimum Data Set (MDS) assessment with the ARD (Assessment Reference Date) of 2/4/13, was reviewed. The section that indicated the number of days in the past 7 days that the resident received antibiotic medication was coded, "2 days." There was a progress note dated 2/1/13 at 1330 (1:30 p.m.), that indicated a Physician Order was received to send the resident to the Emergency Room to evaluate and treat the resident's swollen left arm and change in her mental status. There was a Physician Order dated 2/1/13, that indicated, "Send to (name of hospital) ER (Emergency Room) for change in mental status." There was a Physician's Order dated 2/1/13, signed by the Emergency Department Physician, that indicated, "Nitrofurantoin (Macrobid) (an antibiotic medication) 100 mg (milligrams) take 1 capsule by mouth 2 times daily for 10 days." The assessment for the return from ER that was electronically signed by RN #2 on 2/2/13, indicated the resident returned from the ER with			

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	new orders received for Macrobid 100 mg take one tablet by mouth 2 x day for 10 days. The assessment indicated the resident returned from the ER and "does have a UTI (urinary tract infection)." Interview with RN #2 on 2/19/13 at 2:49 p.m., indicated she was the nurse in charge when the resident returned from the Emergency Room. She indicated the resident returned from the hospital on 2/1/13 with orders for Macrobid for a UTI. Review of the urine culture report dated 2/1/13, indicated the urine had >100,000 colonies of enteroccoccus (type of bacteria) species sensitive to Nitrofurantoin. Review of the February 2013 MAR, indicated the Macrobid was not initiated until 2/3/13 at 9 a.m., the resident did not receive the antibiotic medication at the facility on 2/1/13 or 2/2/13. Interview with the Nursing Consultant on 2/18/13 at 12:20 p.m., indicated the resident was sent to the ER on 2/1/13. She indicated she had a diagnosis of a urinary tract infection. She also indicated the Physician ordered an antibiotic for the UTI,			

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	Macrobid 100 mg. She indicated the medication was available in the facility on 2/1/13 in the PYXIS, a computer generated emergency drug kit. She indicated the medication was not initiated until 2/3/13. The policy titled "Ordering and Receiving Medications from Pharmacy" that was undated, was provided by the Administrator on 2/18/13 at 1:43 p.m. She indicated the policy was current. The policy indicated: "New medications, except for emergency or "stat (immediate)" medications, are ordered as follows: Timely delivery of new orders is required so that medication administration is not delayed. The PYXIS machine is used when the resident needs a medication prior to delivery. If the needed medication is not available in the PYXIS machine, the pharmacy must be phoned immediately and informed the delivery of the medication is needed within four(4) hours." Interview with the Nursing Consultant on 2/18/13 at 3:18 p.m., indicated there was Macrobid available in the PYXIS on 2/1/13, when the medication was ordered by the Physician. She indicated the resident			

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	should have promptly received the antibiotic medication, Macrobid, on 2/1/13 and 2/2/13 to treat the urinary tract infection. 3.1-41(a)(2)			

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F000323 SS=D	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, record review, and interview, the facility failed to following manufacturing recommendations related to an air mattress with bolsters properly fitting on a bed frame for 1 of 3 resident observed for accidents. (Resident #48) Findings included: On 2/12/13 at 12:34 p.m., Resident #48's air mattress with built in bolsters was observed, touching the foot board with a gap of 7 inches from the mattress to the head of the bed while the bed was lying flat. On 2/14/13 at 10:30 a.m., Resident #48's air mattress with built in bolsters was observed, touching the foot board with a gap of 7 inches from the mattress to the head of the bed while the head of the bed was raised. Resident #48's record was reviewed on 2/18/13 at 8:08 a.m. Resident #48's diagnoses included, but were	F000323	F-Tag 323 Free of Accident Hazards/Supervision/Devices: It is the policy of Miller's Merry Manor, Hobart to 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.Resident # 48: Resident experienced no negative outcomes related to the deficient practice. All residents are at risk to be affected by the deficient practice. The maintenance department completed walking rounds of all units to inspect mattress/bed surfaces for proper fit to frame on 2/20/13. All staff will be in-serviced on or before 3/22/13 on the use of spacers and properly fitting mattresses. Staff educated that the use of a spacers is permitted and that spacers should not be removed and only placed at the foot of the bed. Maintenance will be responsible to ensure new mattresses/air mattresses are properly installed and fitted to bed frame prior to resident use. The maintenance director and/or administrator will participate in	03/22/2013

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	not limited to, decubitus ulcer (wound), anemia, diabetes, gastrostomy tube (feeding tube), and colostomy. The February 2013 Physician Recapitulation orders indicated an order dated 1/22/13, to monitor placement of the low air loss mattress to the bed each shift. On 2/18/13 at 9:00 a.m., the resident was observed being pulled up in bed. The mattress was observed at the foot of the bed with bed/mattress straps secured to the bed frame. After the resident was pull up in bed, her head was at the edge of the air mattress with a gap of 7 inches from the mattress to the head of the bed. An interview with the Wound Nurse during this time indicated there was an incident with a previous air mattress where the the resident had swung her legs over, so the current air mattress with bolsters was ordered for her. An owner's manual for the low air loss mattress was provided on 2/18/13 at 3:00 p.m. Page 6 of the product description section indicated the mattress could be placed directly on an existing healthcare bed frame of an appropriate size. On page 7 under		making routine walking rounds of the facility 3x weekly for 4 weeks, then weekly thereafter to monitor for properly fitted mattresses in use. The QA tool titled "General Observations of the Facility Review" (Attachment J) will be utilized. Any identified issues will be immediately corrected and documented on facility QA tracking log. QA tracking logs are reviewed during the monthly facility QA meeting to ensure ongoing compliance.	

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	warnings, the manual indicated to select an appropriate bed system to use with the product. An interview with the Maintenance Supervisor on 2/19/13 at 11:15 a.m., indicated there should have been a spacer at the foot of the bed for the mattress to fit properly on the frame. The Maintenance Supervisor indicated there was a 10-12 inch gap from the mattress to the head of the bed. On 2/19/13 at 2:45 p.m., the Maintenance Supervisor provided a manual on the bed frame regarding its use. On page 13, under the Safety Tips section, the manual indicated the use of mattresses other than their company's may substantially reduce the effectiveness of the safety features and systems incorporated into their beds. 3.1-45(a)(2)			

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F000329 SS=E	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. 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 receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure each resident was free from unnecessary medications related to the lack of indication for the use of a psychotropic medication and the lack of monitoring related to pain medication for 4 of 10 residents reviewed for unnecessary medications. (Resident #26, #58, #67, and #87) Findings include:	F000329	It is the policy of Millers Merry Manor, Hobart that residents be free of unnecessary medications such as psychotropic medication and pain medications without proper indication for use. Resident # 26: It is not the policy of Miller's Merry Manor, Hobart to perform a pre and post assessment of pain for residents receiving routine pain medication. The facility will follow the policy for pain management. The resident has been admitted to hospice services. Resident #58: has been discharged from	03/22/2013

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	1. The record for Resident #67 was reviewed on 2/19/13 at 10:50 a.m. The resident was admitted to facility on 12/15/12. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, and depressive disorder. Physician Orders dated 12/15/12, indicated Lexapro (an antidepressant) 20 milligrams (mg) daily and Klonopin (an anxiolytic) .5 mg at night time. Further review of Physician Orders dated 12/28/12, indicated the Klonopin was discontinued for sleeplessness per family request. Review of Nursing Progress Notes dated 1/9/13 at 10:21 p.m., indicated MD (Physician) was called related to resuming Klonopin .5 mg one daily at night time per family request. Another Physician's Order dated 1/9/13, indicated Klonopin .5 mg at night time. Review of the current plan of care dated 2/15/13 indicated the resident has behavior mood issues and has anxious feelings related to disease		facilityResident # 67: Klonopin was discontinued 2/25/13.Resident # 87: Multiple wheelchair options/ and alternate seating cushions have been trialed with resident to improve wheelchair positioning and comfort. Resident has expressed preference to remain in the same wheelchair with same seating cushion that was observed during annual survey. Resident expresses improved pain management with daily am dose of Tramadol. Physician contacted and desires to continue daily Tramadol. Nursing to assess daily for break thru pain and offer prn pain meds as needed. Prior to administration of any PRN pain medication pre and post assessment of pain level will be completed using a 1-10 scale to evaluate effectiveness. On 3/12/13 the facility ordered another type of cushion to trial in wheelchair upon its arrival.All residents are at risk to be affected by the deficient practice.The nurse managers will complete a chart audit for all active residents to ensure each resident is free from unnecessary psychotropic medications without indication of use and that each resident receiving pain management has monitoring in place per policy by 3/22/13. All licensed nursing staff will be in-serviced regarding facility policies for "Pain Assessment" "Unnecessary Medication Use"	

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	process and sleeplessness: resident has depression. The nursing approaches were to administer psychotropic medication, and to provide education and support to family as needed, document mood behavior and anxious feelings related to disease process and sleeplessness. Review of Nursing Progress Notes and Social Service Progress Notes for 12/12 and 1/13, indicated there was no documentation of the resident having trouble with sleep or anxiety at night time. Review of the Social Service assessment dated 12/26/12, indicated the resident displays mood and behavior problems. Resident displays mood issues as exhibited by anxious feelings related to disease process and sleeplessness. Review of the Behavior Tracking for the period of 12/27/12 through 1/9/13, indicated a "Y" (yes) was coded as the resident having behaviors on 12/27 at 11:38 a.m., on 12/29 at 10:19 a.m. and 7:10 p.m., and on 12/30 at 11:23 a.m. and 9:32 p.m. There was a total of five times the resident was displaying behaviors in that span. Further record review		and "Psychotropic Drug Use" on or before 3/22/13. The pharmacy consultant is scheduled to visit 3/13/13 and 3/14/13 to review each residents current medications for unnecessary use. Recommendations received from consultant will be completed communicated to physician by 3/22/13. Charge nurses will be responsible to use the pain scale of 1-10 to document pain level prior to the delivery of PRN pain medication and then to complete a post pain assessment 30-60minutes following the administration of pain medication. Residents who are receiving routine pain medications for pain management programs will continue to be assessed weekly with weekly summary assessment, pre and post PRN pain medications, during MDS assessment, and with pertinent significant change in status. The PRN pain management form will be used to record the pre and post assessment for PRN pain medication. The social service director and DON will review all residents taking psychotropic medications for proper diagnosis/indication for use and follow facility policy for reductions and psychotropic drug use. The DON or other designee will be responsible to complete the QA tool titled "Behavior and Antipsychotic Medication Review" (Attachment L) on 10 residents	

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	indicated there was no evidence of documentation to indicate if the resident was displaying only anxiety, only sleeplessness, or both at the documented times above. Interview with Social Service Director on 2/19/13 at 2:05 p.m., indicated anyone can document the resident's behaviors in the computer. She further indicated that staff CNAs and nurses will answer yes or no on the computer screen for behaviors but the computer documentation does not specify which behavior the resident was having. She further indicated there was no documentation in Nursing Progress Notes or Social Service Notes related to the resident having sleepless nights while being off the Klonopin. Interview with LPN #4 on 2/19/13 2:12 p.m., indicated she was on leave of absence during most of the time the resident was taken off of the medication. LPN #4 indicated she came back to work on 1/7/13. She indicated she does not recall any nurse indicating the resident was having any difficulty sleeping at night time. 2. Resident #58's record was		per week for the next 4 weeks then monthly thereafter to monitor for ongoing compliance. Any issues will be logged on the facility QA tracking tool. All QA tracking tools are reviewed during the monthly facility QA meeting. The DON or other designee will be responsible to complete the "MAR/TAR/Weekly Summary Review" (Attachment I) daily x1 week, then 3x weekly x 4 weeks, then weekly x4 weeks, and monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected upon discovery and documented on facility QA tracking log. QA tracking logs are reviewed monthly during the facility QA meeting.	

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	reviewed on 02/14/13 at 10:05 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and neuropathy. The physician's orders, dated 01/25/13, indicated an order for roxanol (narcotic pain medication), 5 mg (milligrams) sublingually every two hours as needed for pain or shortness of breath. A physician's order, dated 12/28/12, indicated an order for Percocet (narcotic pain medication) 10-325 mg, two tablets every four hours as needed for pain, The Medication Administration Record (MAR), dated 01/13, indicated the resident received the roxanol without documentation to indicate the reason or the effectiveness of the roxanol on the following dates and times: 01/26/13 at 6 a.m. 01/27/13 at 8 a.m., 10 a.m. and 12 p.m. 01/28/13 three times (no times listed) 01/29/13 two times (no times listed) 01/30/13 at 8 a.m. and 10 a.m. The Nursing Progress Notes on the above dates lacked documentation to indicate the reason the roxanol was			

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	administered, an assessment, and the effectiveness of the medication. The MAR, dated 01/13, indicated the resident received the Percocet without an assessment of the pain and an assessment of the effectiveness of the Percocet on the following dates and times: 01/12/13 twice (no time documented) 01/15/13 at 4 p.m. and 8 p.m. 01/15/13 at 4:15 p.m. 01/17/13 at 3:30 p.m. The Nursing Progress notes on the above dates lacked documentation to indicate an assessment was completed for the pain and the effectiveness of the pain medication. A physician's order, dated 01/31/13, indicated an order to change the roxanol to 5 mg by mouth, every one hour as needed for breakthrough pain or shortness of breath. The MAR, dated 02/13, indicated the resident received the roxanol without documentation to indicate the reason or the effectiveness of the roxanol on the following dates and times: 02/02/13 at 8 a.m., 9 a.m., 10 a.m., 11 a.m., and 12 p.m. 02/03/13 at 12 a.m., 1 a.m., 4 a.m., and 6 a.m.			

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	02/04/13 at 3 p.m., 4 p.m., 5 p.m., 6 p.m., and 7 p.m. 02/05/13 at 6:30 p.m. The Nursing Progress Notes on the above dates lacked documentation to indicate the reason the roxanol was administered, an assessment, and the effectiveness of the medication. During an interview on 02/14/13 at 11:31 a.m., LPN #3 indicated the resident's pain should have been assessed for intensity and where the pain was prior to the administration of the medication, then the nurse should have checked for the effectiveness a half hour to an hour after the medication was administered, and the effectiveness should have been documented. 3. Resident #26's record was reviewed on 2/14/13 at 10:46 a.m. Resident #26's diagnoses included, but were not limited to, hypertension, anxiety, gastrointestinal discomfort (stomach), atrial fibrillation (irregular heart rhythm), neuropathic pain, respiratory failure and depression. A care plan for complaints of gastrointestinal (stomach) discomfort was initiated on 8/17/12. The interventions indicated to administer medications as ordered, monitor for			

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	discomfort, and notify the physician of any abnormal findings. A care plan for chronic pain was initiated on 2/5/13. The goal was for the resident's pain to be controlled at an acceptable level. The interventions indicated to acknowledge the presence of pain and discomfort, monitor for effectiveness of pain medication, and give Norco (pain medication) as ordered. The February 2013 Physician Recapitulation orders indicated on 2/5/13, an order for hydrocodone (pain medication) 5/325 mg (milligrams) was to be given at 6:00 a.m., 2:00 p.m., and 10:00 p.m. for pain management. Review of the February 2013 MAR (Medication Administration Record), indicated the scheduled pain medication was administered as ordered. The February 2013 MAR and the Pain Management flow sheet did not indicate a pre/post assessment for pain had been completed when the resident received her scheduled pain medication.			

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	Interview with the DON on 1:00 p.m. on 2/19/13, indicated the staff should have been assessing the resident's pain with her scheduled pain medications 4. On 2/12/13 at 11:02 a.m., Resident #87 was observed being restless and leaning to the left side of her w/c (wheelchair). The resident's right hand was between her right hip and the inside of her w/c. The resident indicated she was having discomfort with the padding and had been requesting a new pad but never received a new one. An interview with RN #1 on 2/12/13 at 11:30 a.m., indicated she was not aware of the resident's discomfort in her w/c. On 2/14/13 at 10:37 a.m., Resident #87 indicated she needed a better pad in her w/c. She had indicated she had not told anyone about the discomfort she had in her w/c at that time. The resident continued to be leaning to her left side and having her hand placed between her right hip and the w/c. An interview with LPN #3 on 2/14/13 at 11:00 a.m., indicated she was not aware of the resident's need for a			

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	different seat cushion or complaints of pain. An interview with SSD (Social Service Designee) on 2/18/13 at 12:40 p.m., indicated she was not aware of the residents pain or problems with the cushion. Resident #87's record was reviewed on 2/19/13 at 9:30 a.m. Resident #87's diagnoses included, but were not limited to, paraplegia, diabetes mellitus, obesity and polyarthritis. A nursing note dated 1/22/13 at 7:07 a.m., indicated the resident had been asking for tramadol (pain medication) every morning after breakfast. There had been no nursing documentation regarding pain since 11/25/12. An order for Tramadol 37.5/325 mg to be given at 8:00 a.m. was obtained. A care plan for pain was initiated on 3/10/11 and was revised on 1/29/12 with interventions indicating to assess pain using the 0-10 scale, monitor the effectiveness of pain medications, administer pain medication as per physician orders and note the effectiveness, and acknowledge presence of pain and discomfort. The prn (as needed) Pain			

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	Management flow sheet indicated on January 2nd, 3rd, 5th, 6th, 18th, 19th, and 20th, the resident's pain was to the back of her thigh between the hours of 9:00 a.m. to 10 a.m. The January and February 3013 MAR and Pain Management flow sheet did not indicate a pre/post assessment for pain had been completed when the resident received her scheduled pain medication. A Pain Management Program Policy dated 11/30/2010, was provided by the MDS (Minimum Data Set) Coordinator on 2/19/13 at 12:15 p.m. The MDS Coordinator indicated the policy was current. The Policy indicated to assess pain by using the 0-10 numeric/picture scale (1 being mild and 10 being worst pain ever). The Policy indicated the location of the pain, level of pain and the medication and dose administered would be documented. Evaluation of the effectiveness would be determined by reassessing level of pain 30 to 60 minutes post medication administration. The policy indicated, ". . . Documentation of administration of the ordered medication will be initialed on the front of the MAR. D. Location of pain, level of pain and med (medication) and dose administered will be documented on			

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	the Pain Mgt (management) Flow sheet or back (sic) side of (sic) MAR. E. Evaluation of effectiveness will be determined by reassessing level of pain 30-60 minutes post medication administration . . ." An interview with the DON on 1:00 p.m. on 2/19/13, indicated the staff should have been assessing the resident's pain with her scheduled pain medications. 3.1-48(a)(3) 3.1-48(a)(4)			

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	155251		02/20/2013

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F000371 SS=E	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 food was served under sanitary conditions, related to a soiled ice machine, which was full of ice, for 1 of 1 ice machines. This had the potential to affect 62 residents who received ice in the facility. Findings include: During an observation on 02/19/13 at 10:30 a.m., with the Maintenance and Housekeeping Supervisors and Administrator present, the ice machine located off of the main dining room had a black oily substance on a plastic part, which was over the ice in the machine. There was drops of water dripping from the plastic part onto the ice. The ice machine was full of ice. During an interview at the time of the observation, the Maintenance Supervisor indicated the ice machine is delimed and cleaned monthly.	F000371	**F-Tag 371: Food Procure, Store/Prepare/Serve-Sanitary** It is the policy of Miller's Merry Manor, Hobart to store, prepare, distribute and serve food under sanitary conditions. No residents were negatively impacted by the deficient practice. The ice machine was immediately shut down, emptied, and disinfected. 62 of 67 residents had the potential to be affected by this finding. The dietary staff will be in-serviced on or before 3/22/13 on how to inspect the ice machine weekly with the sanitation checklist. The ice machine will be shut down, emptied, and disinfected twice a month a minimum of monthly by maintenance and prn. Dietary staff will be instructed to shut down the ice machine if any issues with cleanliness is noted and report to maintenance immediately. The Dietary manager or other designee will be responsible to complete a weekly inspection of ice machine and document on the QA tool titled "Sanitation Checklist" (Attachment K) completion. Any identified sanitation issues will	03/22/2013

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	A facility policy, dated 07/06 and expired on 02/19/13, titled,, "Disinfecting of Ice Machine", received from the Maintenance Supervisor as current, indicated, "...MONTHLY...wipe down entire inside of machine. This includes all internal ice making parts, grids, slides, shields, and all areas the ice will touch when being made or its travel into the lower bin..." The Monthly Preventive Maintenance Report, dated 01/13, and received from the Maintenance Supervisor as current, indicated the ice machine was last disinfected on 02/07/13. 3.1-21(i)(3)		result in immediate notification to maintenance to shut down, empty and disinfect the ice machine. Issues will be logged on a QA tracking tool. QA tracking tools are reviewed during the monthly facility QA meeting to ensure ongoing compliance.	

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F000386 SS=A	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.			
	Based on record review and interview, the facility failed to ensure Physicians visited and documented progress notes every 60 days for 2 of 28 residents reviewed for physician progress notes. (Residents #26 and # 12) 1. Resident #26's record was reviewed on 2/14/13 at 10:46 a.m. Resident #26's diagnoses included, but were not limited to, hypertension, anxiety, gastrointestinal (stomach) discomfort, atrial fibrillation (irregular heart rhythm), neuropathic pain, respiratory failure and depression. Review of the Physician Progress notes indicated the physician did not document a progress note between June 6, 2012 and September 14, 2012. The resident was admitted to the hospital on October 8, 2012.	F000386	F-Tag386: Physician VisitsIt is the policy of Miller's Merry Manor, Hobart to provide physician services to meet the needs of each resident. Physician must review resident's total program of care including medications and treatments. Resident #26 and # 12: Physician visits are current.All residents are at risk to be affected by the deficient practice.The facility will send a letter to all physicians who presently oversee the care of a resident residing in the facility. The letter will contain information regarding the Federal regulation that each resident must be seen at least every 30days for the first 90days and then at least every 60days for any resident in the facility more than 90days. The medical records designee will notify each physician monthly of visits due in the next 30days. If the physician fails to visit by the date due then the medical records designee will be responsible to inform the facility	03/22/2013

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	An interview with LPN #3 on 2/14/13 at 1:40 p.m., indicated there were no Physician progress notes written between June 6, 2012 and September 14, 2012. 2. Resident #12's record was reviewed on 2/18/13 at 9:30 a.m. Resident #12's diagnoses included, but were not limited to, exacerbation of congestive heart failure, emphysema (lung disease), hypertension, and atrial fibrillation (irregular heart rhythm). Review of the Physician Progress notes and Physician Recapitulation orders indicated the physician did not sign the November 2012 recapitulation orders or write a progress note between October 13, 2012 to January 11, 2013. The December 2012 Recapitulation orders were requested, but were not received. An interview with RN #1 on 2/19/13 at 9:30 a.m., indicated she was not sure when the last time the physician was in the facility to see the resident. 3.1-22(c)(1) 3.1-22(c)(2) 3.1-22(d)(1)		administrator. The facility administrator will then contact the physician's office to request an immediate visit and if visit is not completed within 72hours the medical director will be contacted to review the resident's orders and to make a compliance visit for both the resident and facility. Resident's recapulated orders will be placed on the chart for physician signature and review during physician compliance visits every 30days for the first 90days then every 60days for compliance. The medical records designee will be responsible to complete the QA tool "Physicians Services" (Attachment G) monthly for the next 6 months, then bi-monthly thereafter to monitor for continued compliance. Any identified issues will be communicated to the administrator immediately to be corrected and logged on facility QA tracking log. QA tracking logs are reviewed monthly in facility QA meeting to monitor ongoing compliance.	

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F000425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and interview, the facility failed to ensure medications were disposed according to the facility's policy and procedure for 1 of 6 licensed staff observed during medication pass and for 1 of 11 residents observed during medication pass. (Resident #147) Findings include: During medication pass on 2/19/13 at 8:31 a.m., LPN #5 was observed preparing medications for Resident #147. At that time, the LPN had pulled Tramadol 50 milligrams (mg)	F000425	F-Tag425: Pharmaceutical ServicesIt is the policy of Miller's Merry Manor, Hobart to provide pharmaceutical services to meet the needs of each resident.Resident #147: was not negatively impacted by the deficient practice. LPN # 5 was immediately re-educated on proper disposal of medications on 2/19/13 when DON became aware of deficient practice. All residents are at risk to be affected by the deficient practice.All licensed nurses will be in-serviced by 3/22/13 on the facility policy and procedure for drug disposition using Drug Buster. Disposition of all	03/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/20/2013
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	out of the medication cart and placed it down. When the LPN went to pick up the wrapped pill, it fell out of the wrapper and onto the floor. She then picked it up off the floor and put it in a cup. The LPN indicated she was going to flush the pill down the toilet in the resident's bathroom. The LPN then walked toward Resident #147's room and administered his medications to him in the hallway right outside his room. The LPN then realized the resident's room floor was wet, so she walked down the hallway to the soiled utility room and flushed the Tramadol medication down the hopper toilet. At that time, there were no witnesses to the flushing. Interview with LPN #5 at the time, indicated she was unaware of the facility's policy regarding wasting and the disposition of medication. The LPN further indicated she just knew she had to waste the med since it fell on the floor. Interview with LPN #4 on 2/19/13 at 9:29 a.m., indicated she had thought the med disposition policy was to flush the medication down the hopper toilet with a witness. She further indicated she was not quite sure what		medications requires two licensed nursing staff. The new charge nurse orientation check list has been reviewed to ensure drug disposition policy and Drug Buster use is included with all newly hired nurses. All charge nurses will participate in a medication observation by 3/22/13 to ensure infection control standards are maintained and that each nurse is knowledgeable regarding the proper technique for disposition of medications. The in-service director will continue to complete med pass audits with all nurses quarterly x2 then annually to monitor for ongoing compliance. Any identified issues will be reviewed immediately with nurse upon discovery and logged on QA tracking tool. All QA tracking logs are reviewed monthly during the monthly QA meeting to monitor for ongoing compliance.	

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	the facility's policy was on disposition of the medication. Review of the current 12/11 Drug Buster Medication Disposal System provided by the Director of Nursing (DoN) indicated the policy was to destroy medication in a safe, ecologically friendly manner. The procedure was to obtain medication disposition record, medication to be destroyed and Drug Buster container and take to medication room or work area. In the presence of a licensed witness, document the required information about the medication being destroyed on the medication disposition record. Remove the lid of the Drug Buster and place the medication inside the container. Interview with the DoN on 2/19/13 at 11:20 a.m., indicated all medication wasting and dispositions were to be through the Drug Buster and witnessed by another licensed staff member. 3.1-25(o)			

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	155251		02/20/2013

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F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to	F000441	F-Tag 441: Infection ControlIt is the policy of Miller's Merry Manor,	03/22/2013

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	maintain infection control related the disposition of used lancets, hand washing, uncovered toothbrushes, and the cleansing of equipment after a treatment for 2 of 11 residents observed during medication pass, 1 of 40 rooms observed during environment and for 1 of 2 treatments observed. (Resident's #8, #48, #87, and #149) Findings include: 1. On 2/14/13 at 5:40 a.m., LPN #6 was observed preparing to do a glucometer for Resident #149. The LPN entered the resident's room, applied clean gloves and used an alcohol wipe to wipe the resident's finger. She then pricked the resident's finger with the lancet, obtained the blood and placed it on the strip for the reading. After she was finished she removed her gloves with the lancet inside and threw them away in the garbage can located under the resident's sink. When asked about the whereabouts of the lancet, she indicated she had thrown it away in the garbage can. She then dug through the garbage can and pulled out the lancet. The lancet was capped with the safety device. Interview with LPN #6 at the time,		Hobart to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Resident #8 and # 87: Tooth brushes will be stored in a zip lock bag in resident's bedside table.Resident # 8: No negative outcomes related to the deficient practice. LPN # 5 has been received 1:1 re-education on facility protocol for hand-washing and participated in medication pass observation to ensure knowledge and compliance. Resident #48: Wound nurse was re-educated on 2/20/13 regarding the proper procedure for disinfecting scissors during a dressing change in order to maintain infection control.Resident # 149: Resident was not negatively impacted by deficient practice. LPN # 6 has received 1:1 re-education on facility protocol for disposal of sharps. All residents are at risk to be affected by the deficient practice.All licensed nursing staff in-service will be held on or before 3/22/13 to review the facility policy/procedure for sharps disposal, hand-washing during medication administration, and properly disinfecting scissors after a dressing change. All staff in-serviced on or before 3/22/13 on basic infection control	

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	indicated she always threw the lancets away into the garbage can. She indicated she was unaware of the facility's policy regarding the disposition of the lancets. Interview with LPN #7 on 2/14/13 at 6:24 a.m., indicated lancets were to be disposed in the sharps container and not thrown away. Interview with LPN #4 on 2/14/13 at 7:20 a.m., indicated used lancets were to be thrown away in the sharps container and not in the garbage can. Review of the 6/1/11 current Syringe and Needle Disposal Policy provided by the Director of Nursing, indicated "Immediately after use, syringes and needles were placed into puncture resistant, one-way containers specifically designed for that purpose. 2. On 2/19/13 at 8:31 a.m., LPN #5 was observed pouring and preparing medication for Resident #8. The nurse crushed the resident's pills and placed them into applesauce. She then removed an inhaler from the med cart. The LPN then walked into the resident's room to administer her medication. She administered the		practices and the importance of storing resident personal items separately to maintain infection control. The Nurse managers will be responsible to make random walking rounds on all shifts during medication administration/ treatment administration times to monitor for continued compliance with hand-washing, sharps disposal, and proper cleaning of scissors. All newly hired charge nurses participate in an 11 day orientation program that includes orientation to the facility infection control practices. Each charge nurse performs a return demonstration of proper sharps disposal, hand-washing during medication administration pass, proper cleaning of scissors after dressing change before performing skills independently. The DON or other designee will complete a med/treatment pass observation of all nurses who participate in medication/treatment administration by 3/22/13 to ensure Knowledge. The In-service Director or other designee will be responsible to complete quarterly competencies with all charge nurses for “Hand-washing” and “Med Pass Observation”, "Sharps Disposal", and "Dressing Changes" x 2 quarters then annually to ensure ongoing compliance. Any issues identified during observation will be immediately corrected and	

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	pills first, then without applying clean gloves she administered the inhaler. After the pass, the LPN walked out of the room without washing her hands with soap and water or using alcohol gel. The LPN walked over to her medication cart, signed the resident's medication record and then proceeded to prepare medications for another resident. The LPN did not wash her hands with soap an water or use alcohol gel. Review of the current 7/27/12 Hand Washing and Hand asepsis Policy provided by the Director of Nursing indicated hands should be washed before and after direct resident contact. Interview with LPN #5 on 2/19/13 at 9:15 a.m., indicated she should have used alcohol gel or washed her hands with soap and water after the administration of the inhaler. 3. During an observation on 02/12/13 at 11:17 a.m., the bathroom shared by Resident's #8 and #87 had uncovered toothbrushes stored in the bathroom on a shelf above the sink next to the toilet. During an observation on 02/20/13 at		documented on facility QA tracking tool. The facility reviews all tracking logs during the monthly QA meeting to ensure ongoing compliance.	

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	11 a.m., with the Maintenance and Housekeeping Supervisors and Administrator present, the bathroom shared by Resident's #8 and #87 had three, unlabeled, uncovered toothbrushes stored in an emesis basin, in the bathroom, on a shelf above the sink, next to the toilet. During an interview at the time of the observation, the Administrator did not know who the toothbrushes belonged to. During an interview 02/20/13 at 9:19 a.m., the Director of Nursing and the Nurse Consultant indicated the toothbrushes could be stored labeled, in a plastic bag in the bathroom. 4. On 2/18/13 at 8:44 a.m., the Wound Nurse was observed performing a dressing change to Resident #48's foot wound and sacral wound. The Wound Nurse had prepared her clean dressing field on the resident's bedside table. She removed a pair of scissors from her front pocket and placed it in the middle of her clean dressing field. The Wound Nurse			

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	used the scissors to cut the soiled gauze from the resident's foot. She then placed the scissors on a disposable pad that was on the bed, under the resident's foot. Once she completed the treatment, she was observed placing the scissors back onto the clean field on the bedside table and proceeded with the sacral treatment. Once completed, the Wound Nurse removed the field on the bedside table and placed the scissors directly onto the table. She washed her hands and placed the scissors back into her front pocket without cleaning or sanitizing it. Interview with the Wound Nurse during this time indicated she should have cleaned her scissors before and after use. 3.1-18(j) 3.1-18(l)			

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F000465 SS=F	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 maintain a functional and sanitary environment related to dirt and debris on the residents' rooms and bathroom floors, stained bathroom floor and ceiling tiles, bath basins and bedpans stored uncovered/unlabeled in resident bathrooms, marred walls, floors, and doors, dirty heating units, missing cove base and base board, dirty toilets, torn wheel chair arms and room chair material, broken plastic protectors for doors and walls, stained and torn privacy curtains, stained window curtains, and bent window blinds, bent heating registers, and dirty and torn floor mats in residents' rooms and hallways in 3 of 3 units (West, Central, and East), discolored hair washing sink and accumulation of hair and dirt in 1 of 1 Beauty Shop, which had the potential to affect 30 residents who received Beauty Shop services, accumulation of dryer lint in 3 of 3 dryers in 1 of 1 clean laundry rooms, and paint scraped off tiles, bedpan stored on floor, missing tiles and cracked tiles in 2 of 3 shower rooms. (Central and	F000465	**F-Tag 465: Safe/Functional/Sanitary/Comfortable Environment**It is the policy of Miller's Merry Manor, Hobart to provide a safe and sanitary environment. All issues identified during the environmental tour were corrected on or before 3/22/13. Contractors have been acquired to replace 30 bathroom floors, remove and replace all covebase in central bathrooms, West shower room remodel, resident room entry and bathroom doors are being sanded and stained, new door guards were ordered to replace on every door, all door frames are being replaced on the Central unit and the beauty shop wash bowl has been replaced. Projects began on March 5, 2013. All residents in the facility have the potential to be affected by these findings. An environmental walk through audit was completed to address any other areas that have the potential to affect other residents on 3/4/13.To ensure that this does not re-occur housekeeping supervisor and or designee will conduct daily rounds using the "Room Preparation Checklist" (Attachment M) three rooms, per unit daily for four weeks then two	03/22/2013

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	West). Findings include: Random observations on 2/11/13 and 2/12/13 as well as during the Environmental Tour on 2/19/13 at 9:35 a.m. through 11:35 a.m., with the Administrator, Maintenance and Housekeeping Supervisors, indicated the following: 1. East Unit (E) a. There was an accumulation of dirt and debris around the baseboard and corners of the floor in the bathroom of 105 E. b. There was an accumulation of dirt and debris around the baseboard and corners of the floor and a black substance stained on the caulking of the toilet in the bathroom between rooms 107 E and 109 E. During an interview at the time of the observation on 02/19/13, the Housekeeping Supervisor indicated the bathrooms were cleaned every day. c. There was a four inch piece of cove base pulled away from the wall in the		rooms, per unit weekly thereafter. Housekeeping and maintenance staff will be re-inserviced on cleaning procedures and identifying safety concerns in resident areas. Laundry will be re-inserviced on cleaning the dryer filters. All inservicing will be completed by 3/22/13.Monitoring of the effectiveness of the system will be done weekly for four weeks and then monthly thereafter by the Administrator or designee using the General Observations Audit tool as part of the QA program. Completion date is March 22, 2013. Contractors are involved and will stay until work is completed.	

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	corner near the closet in room 107 E. d. The bathroom floor was soiled with dirt and debris, the caulking around the bottom of the toilet was discolored, and the base of the toilet was dirty in room 111 E. During an interview at the time of the observation on 02/19/13, the Maintenance Supervisor indicated the caulking around the toilet needed to be redone. e. There was a small piece of tile missing by the bed and the bathroom floor tiles were stained and the corners in the bathroom were marred in room 115 E. f. The corner of the wall by the bathroom door was marred in room 118 E. 2. Central Unit (C) a. The door to room 139 C was gouged and there were scratch marks on the bathroom door, and missing cove base by the bathroom door. During an interview at the time of the observation on 02/19/13, the Maintenance Supervisor indicated the sharp edges on the doors are filed			

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	down and painted every month. b. Room 140 C's bathroom walls were marred, and had loose cove base. There were two bedpans, unlabeled and stored in plastic bags on top of each other on the floor in the bathroom and the door to the resident's room was gouged. c. Room 142 C- Bed 1- had a wheelchair which was dirty with dried food spillage. The pad on the foot pedals of the wheelchair was also dirty. There were scrapes on wall next to the bed, a torn privacy curtain and the room door frame had gouges. d. The bathroom between rooms 142 C and 144 C had marred walls, missing caulking around the toilet, and missing floor tile along the base board, and stained ceiling tiles. e. Room 144 C- the wall behind the resident's lazy boy chair was marred with black marks and gouges. f. Room 146 C- a mat on the floor next to the bed was dirty. The vinyl blinds were bent, crinkled and backwards and there were stains on the curtain of the window. The privacy curtain was stained.			

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	g. The bathroom shared by rooms 146 C and 148 C- had spackle on the floor tile by the toilet. h. Room 147 C-the door to the room had gouges. i. The bathroom shared by rooms 147 C and 149 C- had stained ceiling tiles and the wall was discolored and the bathroom door was scratched and marred. j. Room 149 C-there was a dirty mat on the floor beside bed 2. k. Room 150 C-the bathroom had stained ceiling tiles and the door to the room had chips with sharp edges. l. Room 151 C-the wall behind bed 2 was gouged. The white floor register by the resident's room door was dented and dirty. The door to the room was marred and the over the bed table was dirty and the base of the table had food spillage. There was a 4 inch piece of cove base tile on the floor missing and a missing tile in the bathroom and the bathroom door is marred. m. The Central Unit shower room-the rubber coating on the shower tiles was scraping off.			

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	3. West Unit (W) a. The West Shower Room-had a bedpan uncovered and unlabeled, stored on the floor by the toilet, stained shower curtains, missing tiles on the floor, and cracked tile on the wall between the showers. During an interview at the time of the observation on 02/19/13, the Maintenance Supervisor indicated he was unsure why the bedpan was on the floor next to the toilet. b. The fire door leading to the West Unit had a broken plastic door protector which had sharp edges. c. Room 105 W-there was a torn mat on the floor. d. Room 108 W-the room door had scratches and was marred. The bathroom door was marred on the inside and outside of the door and the walls were gouged below the over the bed light of bed 2. There was stained caulking around the bottom of the toilet, there were yellow stains on the floor tiles, and loose base board under the sink in the bathroom. e. Room 109 W-there were spaces			

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	between the floor tile in the bathroom. During an interview at the time of the observation, the Maintenance Supervisor indicated it had looked like the tile had been cut wrong. f. Room 110 W-a plastic strip on the bathroom wall was loose and had sharp edges. The arms and back of the wheelchair by Bed 2 was torn and in need of repair. The anti-slip strips on the floor by Bed 1 were peeling off. g. Room 111 W-the bathroom had marred walls, discolored floor tiles, and discolored caulking around the toilet. h. Room 113 W-there was a four inch piece of cove base missing in the bathroom, yellow stained floor tiles, and the bathroom door was marred and scratched. i. Room 115 W- in the bathroom, the wall next to the toilet had a hole with chipped paint, the floor tiles had yellow stains, the wall in front of the toilet had a large square board that was pulling apart from the wall. The floor in the resident's room was marred with a brownish/black substance under the bed.			

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	j. Room 116 W-in the bathroom there were yellow stains around the toilet, chipped paint around the sink caulking. In the resident's room, the stationary chair had chipped paint and the arms of the chair were rough to touch and there was a tear on the back of chair. k. Room 118 W-the corners of the room door had marred plaster. There was missing cove base by the bathroom door. There was a bath basin, unlabeled and uncovered, stored on the bathroom floor. l. Room 121 W- there were two bath basins stored uncovered and unlabeled, stacked on the back of the toilet in the bathroom and the soap dispenser had a build up of a dark orange substance under the dispenser. In the resident's room, Bed-2 had soiled side rails and there was a brown substance splattered on the wall behind the head of the bed. There was a discoloration on the ceiling tiles, a dried brown substance on the window sill, the heat registry was dirty. m. Room 122 W-there was a brown marred area on the floor in the center of the room, the anti-slip floor strips under the bed were partially gone.			

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	The anti-slip floor strips in the bathroom were pulling up and the ring, which goes under the hot water faucet was missing. n. Room 123 W-there were two bath basins stored uncovered and unlabeled, stored in the bathroom. o. Room 124 W-there were two bath basins, uncovered and unlabeled, stored in the bathroom and there were stains on the floor tile in the bathroom. The privacy curtain between the beds was dirty and there was stains on the window curtain. The caulking by the heating vent was dirty/dusty, the floors in front of bed 2 was marred. There was caulking on the window sill from a crack in the sill. p. Room 125 W-there were marred walls and the floor was dirty. q. Room 128 W-there was a bath basin behind the resident's recliner, the heating unit was dirty/dusty and there is a space between the heating unit and the wall. r. Room 129 W-there was a crack along the wall near the floor base board to the heater. The ceiling tiles in the bathroom were cracked and loose from the brace holding the tile			

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	up. The wheelchair in the room was dirty and the arms of the chair were cracked and peeling. s. Room 130 W-the privacy curtain was dirty. There was a space between the wall and the heating unit and the heating unit had an orange substance smeared on the top of the unit and the vents of the unit was dirty. There was chipped paint and plaster above the sink in the bathroom. During an interview at the time of the observation on 02/19/13, the Maintenance Supervisor indicated it looked like someone had spilled something on the heating unit and tried to wipe it up. During an interview on 02/20/13 at 9:19 a.m., the DoN (Director of Nursing) and the Corporate RN Consultant indicated the bath basins and bedpans could be stored covered with plastic bags and should not have been stored on the floor. They indicated the bath basins and bedpans could be store in the bathroom as long as they are labeled. A facility policy, undated, and untitled, received from the Director of Nursing on 02/20/13 at 9:13 a.m. indicated, ".			

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	. . WINDOWS AND PRIVACY CURTAINS...1) Privacy curtains will be laundered every six months or as needed to remain clean at all times . . . " 4. Clean Laundry Room-three of three dryers had an accumulation of lint, which was hanging from the lint traps and was accumulated on the floor and corners of the bottom of the dryers. During an interview on 02/20/13 at 10:45 a.m., Laundry Aide #1 indicated she had not emptied the lint traps yet today. She indicated the lint traps are emptied three times a day. During an interview on 02/20/13 at 10 :45 a.m., the Housekeeping Supervisor indicated the Laundry Aide #1 had been working since 7 a.m. this morning. An undated facility policy, titled, "Dryer Filter Cleaning Procedure", received from the Maintenance Supervisor as current on 02/19/13 at 2 p.m., indicated, "Dryer filters are to be inspected daily at the beginning of each shift and the filters are to be cleaned at the end of each shift . . . " The "Lint Checklist", received from			

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	the Maintenance Supervisor on 02/19/13 at 2 p.m. indicated the last time the lint had been cleaned from the dryers was at 2 p.m. on 02/18/13. 5. Beauty Shop-there was a discoloration of the inside of the hair washing sink and there was an accumulation of hair and dirt under the hair washing sink. During an interview at the time of the observation, the Beautician indicated the facility had fixed the sink and had used chemicals which discolored the hair washing sink. She indicated it did not look like the hair and dirt had been cleaned up, "recently". A facility policy, undated, and untitled, received from the Director of Nursing on 02/20/13 at 9:13 a.m. indicated, ". . . U. BEAUTY SHOP- DAILY Procedure: The beautician shall be responsible for the daily cleaning of the room...Weekly the housekeeping (sic) Department will dust, sweep, and mop the floor . . ." 3.1-19(f)			