

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155297	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/19/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S HEALTH & REHAB BY MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00158139.</p> <p>Complaint IN00158139-Substantiated. Federal/State deficiency related to the allegation is cited at F309.</p> <p>Survey dates: December 15, 16, 17, 18, and 19, 2014.</p> <p>Facility number: 000194 Provider number: 155297 Aim number: 100267790</p> <p>Survey team: Yolanda Love, RN-TC Lara Richards, RN Heather Tuttle, RN</p> <p>Census bed type: SNF/NF: 46 Total: 46</p> <p>Census payor type: Medicare: 18 Medicaid: 13 Other: 15 Total: 46</p> <p>These deficiencies reflect State findings</p>	F000000	Please accept this as our credible allegation of compliance. The facility respectfully requests paper compliance for the below Plan of Correction.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F000164 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 26, 2014, by Janelyn Kulik, RN.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The facility must keep confidential all</p>			

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	<p>information contained in the resident's records, regardless of the form or storage methods, except when release is required by law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to ensure the confidentiality of the resident's medication administration record was maintained for 2 of 7 residents observed during medication administration. (Residents #142 and #143)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 12/17/14 at 5:02 p.m., the medication cart was observed outside of Resident #143's room. The medication book was open at this time and the resident's medication administration record was visible. LPN #1 was in the resident's room with the door closed at this time. <p>Interview with the Director of Nursing on 12/19/14 at 12:33 p.m., indicated the medication books should be closed when staff were not in the area to maintain resident confidentiality.</p> <ol style="list-style-type: none"> On 12/17/14 at 5:43 p.m., RN #1 was observed to enter Resident #142's room. The RN did not close the medication book that was located on top of the 	F000164	<p>It is the policy of Miller's Health and Rehab of LaPorte that residents have the right to personal privacy and confidentiality of his or her personal clinical records Resident #142 and Resident #143: Medical/clinical records will be maintained/secured per policy to ensure resident privacy RN 1 and LPN 1 have been re-educated on procedure for maintaining resident privacy during medication administration All residents are at risk to be affected by the deficient practice. All licensed nursing staff will be in-serviced on resident's right to privacy on or before 1/14/2015. Charge nurses will be instructed on maintaining resident's privacy during medication pass by ensuring book is closed when left unattended on medication cart. The nurse managers will participate in routine walking rounds on various shifts at medication administration times to monitor that nurses are maintaining privacy. The corrective action will be monitored utilizing the QA tool titled "Quality Care Review" (Attachment A) The tool will be completed daily x1 week, then 3x weekly for 3</p>	01/18/2015

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	<p>medication cart in the hallway. The resident's medication administration record was visible at this time.</p> <p>Interview with the Director of Nursing on 12/19/14 at 12:33 p.m., indicated the medication books should be closed when staff were not in the area to maintain resident confidentiality.</p> <p>3.1-3(p)(4)</p>		<p>weeks, weekly x 4 weeks, then monthly by 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 during facility quality assurance meeting to ensure ongoing compliance.</p>				
F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review, and interview, the facility failed to ensure all residents were free from physical restraints used to treat the resident's medical symptoms related to the use of a seatbelt restraint attached to an electric wheelchair for 1 of 2 residents reviewed for restraints of the 2 residents who met the criteria for restraints. (Resident #26)</p>	F000221	<p>It is the policy of Miller's Health and Rehab that residents have the right to be free from physical restraints. Resident #26: 12/18/2014 IDT met to review plan of care with resident and family. Seatbelt device was removed from electric scooter. All residents are at risk to be affected by the deficient practice. The nurse management team completed an audit to ensure no other residents were affected by</p>	01/18/2015			

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	<p>Findings include:</p> <p>On 12/16/14 at 8:55 a.m., Resident #26 was observed sitting in an electric wheelchair with a clip seatbelt restraint around her waist. The resident was not leaning forward or to one side. Interview with the resident at that time, indicated she did not particularly like the seatbelt, and really did not know why she had to wear it. She indicated staff clip the belt around her waist because she was unable to do it herself.</p> <p>On 12/17/14 at 9:30 a.m., the resident was observed sitting in the electric wheelchair with a clip seatbelt restraint across her lap and waist. The resident was not leaning forward or to one side.</p> <p>On 12/17/2014 2:30 p.m., LPN #2 was asked if the resident could remove her seatbelt herself. At that time, the LPN walked into the resident's room and asked the resident if she could unclip the seatbelt by herself. The resident tried three times to unclip the seatbelt but was unsuccessful. The resident then asked the nurse "Was it necessary to have this belt around my waist?" The LPN explained to the resident when she first got the electric wheelchair her family put the seatbelt around her waist, because the chair was very new to her. The LPN then</p>		<p>the deficient practice. All nursing staff will be in-serviced by 1/14/2015 regarding facility policy for use of restraints. Prior to initiation of any restraining device a physician's order with diagnosis for use will be obtained, IDT resident restraint/device assessment will be completed, and the resident/resident POA will be advised of the benefits vs. risk for use of a restraint, and HCP updated to reflect use of such device. The nurse managers participate in routine walking rounds and will be responsible to monitor for use of any restraining/devices and to ensure that proper assessment and evaluation is completed prior to use. The DON or other designee will be responsible to complete the "Restraint Review" (Attachment B) weekly x 4 weeks, then monthly there after to ensure ongoing compliance. 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.</p>		

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	<p>removed the belt and tied it around the back of the chair and fastened it so it would not drag on the ground.</p> <p>On 12/18/14 at 8:30 a.m., the resident was observed sitting in the electric wheelchair in dining room. The resident was not leaning forward or to one side. At that time, the seatbelt restraint was observed around her waist and fastened. The Director of Nursing then asked the resident if she could release the belt, again the resident could not. The resident asked the DON if the belt was necessary.</p> <p>Interview with the Director of Nursing (DON) at the time, indicated the resident's family had placed the seatbelt around her waist when she first got the chair.</p> <p>The record for Resident #26 was reviewed on 12/17/14 at 11:13 a.m. The resident's diagnoses included, but were not limited to, cerebrovascular disease, chronic kidney disease, urinary obstruction, hemiplegia, anemia, lack of coordination, high blood pressure, diabetes, and grand mal seizures.</p> <p>Review of the Quarterly Minimum Data Set (MDS) 10/8/14 assessment indicated the resident's Brief Interview for Mental Status (BIMS) score was 14, indicating</p>				

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	<p>she was alert and oriented. The resident was coded as not having a physical restraint.</p> <p>Review of Physician orders on the current 12/2014 recap indicated there was no Physician order for the seatbelt restraint.</p> <p>Further record review indicated there was no restraint assessment for the seatbelt restraint, nor was there a care plan for the restraint.</p> <p>Interview with CNA #1 on 12/17/14 at 2:15 p.m., indicated the resident's electric wheelchair comes with a the seatbelt so they just fasten it around her waist otherwise it will drag on the ground.</p> <p>Interview with LPN #2 on 12/17/14 at 3:25 p.m. indicated there was no doctor's order for the seatbelt or a restraint assessment.</p> <p>Interview with the DON on 12/18/14 at 8:40 a.m., indicated she was unsure if the family wanted the resident to have the seatbelt or not.</p> <p>3.1-26(o)</p>						

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each residents' dignity was maintained related to staff failing to knock on the door before entering a residents' room.</p> <p>The facility also failed to ensure a resident's dignity was maintained related to dressing a resident in a soiled immobilizer for 2 of 3 residents reviewed for dignity of the 3 residents who met the criteria for dignity. (Residents #137 and #138)</p> <p>Findings include:</p> <p>1. On 12/16/2014 at 8:28 a.m., CNA #2 entered Resident #137's room without knocking before entering.</p> <p>The record for Resident #137 was reviewed on 12/19/14 at 9:42 a.m. The resident's diagnoses included, but were not limited to, closed fracture, hypertension and pacemaker.</p>	F000241	<p>It is the policy of Miller's Health and Rehab, LaPorte to promote care for the residents in an environment that maintains or enhances each resident's dignity and respect full recognition of his or her individuality. Resident # 137: Staff will knock on resident's door and request permission to enter prior to going into resident's room. Resident # 138: 12/17/14 the immobilizer was removed to be cleaned and a new immobilizer applied. Staff instructed on importance of changing immobilizer with any evidence of soiling promptly to maintain resident dignity. All residents are at risk to be affected by the deficient practice.</p> <p>An all staff in-service will be held on or before 1/14/15 to educate staff on the importance of knocking on residents door and requesting permission to enter prior to entering residents room.</p> <p>Staff will be in-serviced that assistive devices/immobilizers etc... need to be removed promptly upon discovery of soiling and replaced to ensure that</p>	01/18/2015
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	<p>The admission Minimum Data Set Assessment dated 12/18/14, indicated the resident's Brief Interview for Mental Status (BIMS) score of 7, indicating the resident was severely impaired cognitively.</p> <p>Interview with the Unit Manager on 12/19/2014 at 9:39 a.m., indicated staff should knock before entering a resident's room.</p> <p>2. On 12/16/2014 at 11:02 a.m., Resident #138 was observed wearing a white immobilizer which was stained and soiled.</p> <p>On 12/17/2014 at 11:10 a.m., Resident #138 was observed wearing the same stained and soiled immobilizer.</p> <p>The record for Resident #138 was reviewed on 12/16/14 at 3:00 p.m. The resident's diagnoses included, but were not limited to, fracture of femur neck, diabetes, and depression.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated 11/19/14, indicated the resident's Brief Interview for Mental Status (BIMS) score was 7, indicating the resident was severely impaired cognitively.</p>		<p>dignity is maintained at all times. Nursing will be instructed to add monitoring of immobilizer, slings, casting devices for soiling a minimum of each shift and PRN. The facility will also make efforts as practical to have at least two devices on hand so that upon discovery of soiling the device can be changed out with the spare. The administrator, social services 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 resident are treated with and provided care in a dignified manner. The corrective action will be monitored utilizing the QA tool "Quality Care Review" (Attachment A). Tool will be completed daily x1 week, 3xweekly x3 weeks, weekly x4 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. resident's dignity and respect in full recognition of his or her individuality.</p>		

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F000272 SS=D	<p>Interview with the Physical Therapist on 12/17/14 at 11:15 a.m., indicated there was a new immobilizer ordered for the resident and the stained and soiled immobilizer would be sent to the laundry.</p> <p>Interview with the Unit Manager on 12/19/14 at 9:35 a.m., indicated she observed the resident's soiled and stained immobilizer on 12/17/14 and sent it to the laundry.</p> <p>3.1-3(t)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;</p>			

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	<p>Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure restraint assessments were completed related to the use of seatbelt restraints for 1 of 2 residents reviewed for restraints of the 2 residents who met the criteria for restraints. (Residents #26)</p> <p>Findings include:</p> <p>On 12/16/14 at 8:55 a.m., Resident #26 was observed sitting in an electric wheelchair with a clip seatbelt restraint around her waist. The resident was not leaning forward or to one side. Interview</p>	F000272	<p>It is the policy of Miller's Health and Rehab that residents have the right to be free from physical restraints. Resident #26: 12/18/2014 IDT met to review plan of care with resident and family. Seatbelt device was removed from electric scooter. All residents are at risk to be affected by the deficient practice. The nurse management team completed an audit to ensure no other residents were affected by the deficient practice. All nursing staff will be in-serviced by 1/14/2015 regarding facility policy for use of restraints. Prior to initiation of any restraining device a physician's order with</p>	01/18/2015

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	<p>with the resident at that time, indicated she did not particularly like it, and really did not know why she had to wear it. She indicated staff clip the belt around her waist because she was unable to do it herself.</p> <p>On 12/17/14 at 9:30 a.m., the resident was observed sitting in the electric wheelchair with a clip seatbelt restraint across her lap and waist. The resident was not leaning forward or to one side.</p> <p>On 12/17/2014 2:30 p.m., LPN #2 was asked if the resident could remove her seatbelt herself. At that time, the LPN walked into the resident's room and asked the resident if she could unclip the seatbelt by herself. The resident tried three times to unclip the seatbelt but was unsuccessful. The resident then asked the nurse "Was it necessary to have this belt around my waist?" The LPN explained to the resident when she first got the electric wheelchair her family put the seatbelt around her waist, because the chair was very new to her. The LPN then removed the belt and tied it around the back of the chair and fastened it so it would not drag on the ground.</p> <p>On 12/18/14 at 8:30 a.m., the resident was observed sitting in the electric wheelchair in dining room. The resident</p>		<p>diagnosis for use will be obtained, IDT resident restraint/device assessment will be completed, and the resident/resident POA will be advised of the benefits vs. risk for use of a restraint, and HCP updated to reflect use of such device. The nurse managers participate in routine walking rounds and will be responsible to monitor for use of any restraining/devices and to ensure that proper assessment and evaluation is completed prior to use. The DON or other designee will be responsible to complete the "Restraint Review" (Attachment B) weekly x 4 weeks, then monthly there after to ensure ongoing compliance. 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.</p>		

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	<p>was not leaning forward or to one side. At that time. the seatbelt restraint was observed around her waist and fastened. The Director of Nursing then asked the resident if she could release the belt, again the resident could not. The resident asked the DON if the belt was necessary.</p> <p>Interview with the Director of Nursing (DON) at the time, indicated the resident's family had placed the seatbelt around her waist when she first got the chair.</p> <p>The record for Resident #26 was reviewed on 12/17/14 at 11:13 a.m. The resident's diagnoses included, but were not limited to, cerebrovascular disease, chronic kidney disease, urinary obstruction, hemiplegia, anemia, lack of coordination, high blood pressure, diabetes, and grand mal seizures.</p> <p>Review of the Quarterly Minimum Data Set (MDS) 10/8/14 assessment indicated the resident's Brief Interview for Mental Status (BIMS) score was 14, indicating she was alert and oriented. The resident was coded as not having a physical restraint.</p> <p>Further record review indicated there was no restraint assessment for the seatbelt restraint.</p>			

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F000309 SS=D	<p>Interview with LPN #2 on 12/17/14 at 3:25 p.m. indicated there was no restraint assessment completed for the seatbelt.</p> <p>3.1-31(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to monitor and assess bruising for 1 of 4 residents reviewed for skin conditions (non-pressure related) of the 10 residents who met the criteria for skin conditions (non-pressure related). (Resident #C)</p> <p>Findings include:</p> <p>On 12/15/14 at 10:33 a.m., Resident #C was observed with two areas of dark purple/bluish bruising to the top of his right hand.</p> <p>On 12/17/14 at 12:24 p.m., 2:10 p.m., 4:30 p.m., and 6:48 p.m., the areas of</p>	F000309	<p>It is the policy of Miller's Health and Rehab, LaPorte to ensure each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>Resident C: Assessment was completed and documented for resident. Family and physician were notified per policy and HCP reviewed/updated. All residents are at risk to be affected by the deficient practice. A head to toe assessment of all residents in the facility will be completed on or before 1/14/15 to ensure that other residents are not affected by the deficient practice. All nursing staff will be in-serviced by 1/14/15 on the facility policy for</p>	01/18/2015

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	<p>bruising remained to the resident's right hand.</p> <p>On 12/18/14 at 10:35 a.m., the resident was observed with the dark purple/bluish bruising to his right hand.</p> <p>The record for Resident #C was reviewed on 12/17/14 at 1:33 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and diabetes.</p> <p>The 12/13/14 New Skin Alteration assessment form, indicated the resident was being monitored for areas to his groin. There was no documentation related to bruises on his right hand.</p> <p>The Nursing progress notes dated 12/15/14, indicated there was no documentation related to bruising to the resident's right hand.</p> <p>The 12/2014 Medication and Treatment Administration records, indicated there was no documentation related to monitoring of the resident's bruises.</p> <p>Interview with the Director of Nursing on 12/19/14 at 11:18 a.m., indicated the resident had some discoloration to his right hand and it should have been monitored for seven days on the medication or treatment records.</p>		<p>assessing, documenting, investigating, and monitoring areas of bruising. Upon discovery of a bruise the nurse will be responsible to initiate documentation in the EMR per facility protocols. Each resident receives a head to toe skin assessment upon admission to facility and for the next 72 hours, then a minimum of weekly by licensed nurse, and with any pertinent condition change. Nurse aides will be instructed to report any new areas of skin alteration (including bruises) to nurse upon discovery. The EMR dashboard/24 hour report is automatically triggered when new onset of bruising/skin alteration is initiated by charge nurse. The nurse management team reviews the EMR dashboard routinely to monitor that resident condition changes are assessed/treated/evaluated per plan of care. The corrective action will be monitored utilizing the "Quality of Care" (Attachment A) Tool will be completed by the DON or other designee daily x1week, then 3x weekly x3 weeks, weekly x4 weeks, then monthly thereafter. Any concerns identified will be documented on QA 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.</p>				

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F000323 SS=D	<p>This Federal tag relates to Complaint IN00158139.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure oxygen was stored properly for 1 of 2 floors. The facility also failed to ensure there was adequate supervision to prevent accidents for 1 of 3 residents reviewed for accidents of the 4 residents who met the criteria for accidents. (Resident #7 and the 6th floor)</p> <p>Findings include:</p> <p>1. On 12/18/14 1:46 p.m., on the 6th floor in the oxygen therapy room, there was 1 tank of oxygen standing on top of the oxygen storage chest. At that time, there was also a tank of oxygen standing</p>	F000323	It is the policy of Miller's Health and Rehab, LaPorte to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Resident #7: experienced no negative outcomes related to deficient practice 6th Floor oxygen storage room: on 12/18/14 following ISDH discovery the oxygen cylinders were all properly secured and re-education initiated with staff on protocol to secure/store oxygen. All residents are at risk to be affected by the deficient practice. An all staff in-service will be completed on or before 1/14/15 to review facility policies for	01/18/2015

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	<p>upright directly on the floor. Both tanks were not secured.</p> <p>Interview with the Nurse Consultant on 12/18/14 at 1:50 p.m., indicated the small refill tank on top of the oxygen storage chest was not used at all since this corporation took over in June of 2014 it had belonged to the hospital. She further indicated the large tank of oxygen standing on the floor was to be secured.</p> <p>Review of the current 12/30/2011 Transferring and Storage of Oxygen policy provided by the Administrator indicated, "Storage of Oxygen will meet the following requirements: Oxygen cylinders will be secured from tipping."</p> <p>2. Staff interview with LPN #2 on 12/15/14 at 11:11 a.m., indicated Resident #7 just had a recent fall from his wheelchair on 12/3/14.</p> <p>On 12/16/2014 9:05 a.m., Resident #7 was observed seated in a wheelchair in the dining room as well as another resident. Both residents were unsupervised at the time. At that time, the resident stood up from his chair, and the chair alarm noted to the back of the chair sounded. There was no staff in the dining room as he stood up. The resident then sat back down and tried to move his</p>		<p>supervision and fall prevention. The nurse aide assignment sheets will serve as the communication tool for staff to share resident specific interventions for fall prevention. Nursing staff will be instructed that oxygen cylinders be stored/secured in holder and not loose/standing directly on floor. Nurse managers and administrator will make routine walking rounds and will inspect oxygen storage rooms during random tours to monitor that oxygen cylinders are stored properly. Additionally during random walking rounds the managers will monitor for adequate resident supervision to prevent reduce incident/accidents. The corrective action will be monitored utilizing the QA tool titled "Quality Care Review" (Attachment A) The tool will be completed daily x1 week, then 3x weekly for 3 weeks, weekly x 4 weeks, then monthly by 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 during facility quality assurance meeting to ensure ongoing compliance.</p>				

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	<p>wheelchair forward, but it was locked. He continued to grab at the table to move his wheelchair forward.</p> <p>Continued observation at 9:15 a.m., indicated the resident stood up again, this time it was longer and he attempted to walk forward. At that time, LPN #2 was summoned to the dining room to attend to the resident. The LPN instructed the resident to sit down in which he did and she wheeled him out of the dining room to the Nurse's station.</p> <p>On 12/17/14 at 2:15 p.m., the resident was observed sitting in a wheelchair in the dining room. There were several other residents in the room, however, there was no staff around. There was a CNA in a resident's room with the door closed and the nurse was in another room. At 2:20 p.m., the nurse came into the dining room to assist another resident to his room, however, she left Resident #7 seated in his wheelchair as well as three other residents in the dining room by themselves.</p> <p>The record for Resident #7 was reviewed on 12/18/14 at 10:55 a.m. The resident's diagnoses included, but were not limited to, chronic airway obstruction, cerebellar ataxia, pacemaker, chronic kidney disease, dementia without behavioral</p>			

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	<p>disturbance, and high blood pressure.</p> <p>The 11/26/14 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented with a Brief Interview for Mental Status (BIMS) score of 1. The resident needed extensive assist with two person physical assist for bed mobility and transfers. The resident had a history of falls since the last admission or prior assessment of two or more with no major injury.</p> <p>Review of the current care plan dated 10/15/14 indicated the resident was a fall risk, characterized by the following risk factors: history of falls, confusion and dementia. The resident also had a fall on 10/13/14 with an abrasion to the right knee.</p> <p>The fall risk assessment dated 6/25/14 indicated the resident was a low risk for falls with the score of 16.</p> <p>The incident investigation dated 12/3/14 indicated the resident was sitting in a wheelchair at Nurse's station with alarm in place, he attempted to stand unassisted and fell. The resident was sitting in a wheelchair with alarm on, the alarm sounded and by the time staff arrived the resident had fallen. The Manager Review Investigation indicated, on the care</p>			

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F000329 SS=D	<p>routine section, "Resident is not to be left alone in Nurse's station."</p> <p>Interview with LPN #2 on 12/16/14 at 3:25 p.m., indicated the resident was not to be left alone anywhere because of his past history of falls.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>			

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	<p>Based on record review and interview, the facility failed to ensure the resident's drug regimen was free from unnecessary drugs related to no indication for the use of an as needed (prn) anti-anxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #136)</p> <p>Findings include:</p> <p>The record for Resident #136 was reviewed on 12/17/14 at 3:37 p.m. The resident's diagnosis included, but was not limited to, anxiety.</p> <p>A Physician's order dated 12/10/14, indicated the resident was to receive Lorazepam (an anti-anxiety medication) 1 milligram (mg) give 0.5 tab as needed (prn) for anxiety at bedtime.</p> <p>The December 2014 Medication Administration Record (MAR), indicated the resident received the prn Lorazepam on 12/15 and 12/16/14. There was no documentation on the prn protocol flow sheet indicating the resident's anxiety and/or what interventions were attempted prior to giving the medication.</p> <p>Interview with the Director of Nursing on 12/19/14 at 9:28 a.m., indicated the resident's anxiety and what interventions</p>	F000329	<p>It is the policy of Miller's Health and Rehab, LaPorte that residents be free of unnecessary medications such as anti-anxiety medications without proper indication for use. Resident # 136: Has been discharged from facility All residents receiving prn anti-anxiety medications are at risk to be affected by the deficient practice. Social service designee and nurse managers will complete a chart audit for all residents who have an order for prn anti-anxiety use by 1/14/15 to ensure each resident's plan of care includes non-pharmacological interventions prior to use of prn antianxiety medication administration. Nurse staff will be in-serviced by 1/14/15 on facility policy for administering prn anti-anxiety medication to ensure that proper indication of use is evident prior to administration of prn dose. The consultant pharmacist reviews each residents drug regimen a minimum of monthly and will continue to make recommendations as appropriate to physicians in an effort to reduce/prevent use of unnecessary medications. Nurses will be instructed to follow interventions per resident specific HCP and to assess for effectiveness of interventions prior to use of prn antianxiety medication to ensure proper indication for use. The social</p>	01/18/2015			

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F000371 SS=F	<p>were attempted prior to giving the medication should have been documented.</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure the food was stored and prepared under sanitary conditions related to, boxes stored on the freezer floor, pots and pans stored on top of each other and wet, and hand washing and glove removal while preparing food for 1 of 1 kitchens. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. On 12/18/14 at 1:17 p.m., Dietary Aide #1 was observed wearing gloves to both of her hands. At that time, she was observed putting food into her mouth.</p>	F000371	<p>service director will be responsible complete the QA tool titled "Quality of Care" (Attachment A) on 6 residents per week for the next 4 weeks then monthly. Any issues will be logged on facility QA tracking tool. All QA tracking tools are reviewed during the monthly facility Quality Assurance Meetings to ensure ongoing compliance.</p> <p>It is the policy of Miller's Health and Rehab, LaPorte to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and Store, prepare, distribute and serve food under sanitary conditions. No residents were negatively impacted by the deficient practice. Dietary Aide #1 was immediately educated on proper procedure for glove removal, hand washing, and personal food items in the food preparation areas. The Dish Machine Aide was immediately educated on the proper ways to store wet pans on the drying racks ensuring that water does not collect in the pans while drying. The</p>	01/18/2015			

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	<p>The Dietary Aide was standing at a food preparation table. The Dietary Aide put the food down, upon walking into the kitchen. There was a half eaten cheese Danish laying on the counter top where food was being prepared. The Dietary Aide left the area to get someone for the full kitchen sanitation tour. At the time, she was observed wearing the same pair of gloves she ate the Danish with. She came back to the food preparation table and with the same gloved hands, proceeded to pull frozen biscuits out of a box with her hands. She placed them on the cutting board and walked over to the wall and grabbed a knife. She came back to the table and proceeded to cut the biscuits with the same pair of gloves to her hands.</p> <p>Interview with Dietary Aide #1 at that time, indicated as far as she knew it was ok to eat in the kitchen while preparing food. She stated "they let me." She then removed her gloves and donned a clean pair of gloves without washing her hands with soap and water or using alcohol gel.</p> <p>Interview with Dietary Cook #1 at that time, indicated the Dietary Aide was not supposed to be eating in the food preparation area.</p> <p>Interview with the Dietary Food Manager</p>		<p>boxes stored on the freezer floor were immediately removed and placed on the crates. 46 of 46 residents had the potential to be affected by this finding. All kitchen staff will be educated on or before 1/18/14 on the proper procedure for food handling in food preparation area, glove removal and hand washing, food storage in freezer and refrigerators, and the storage of clean dishes and utensils on the drying racks.</p> <p>The dietary food manager, administrator, or designee will be responsible to complete the "Follow-up for State Regulation TAG371" (Attachment E) each day for the first week, twice a week for 4 weeks, and finally once a week for 5 months. Any identified sanitation or food handling issues will result in immediate resolution along with education provided to the appropriate kitchen employee. The QA tool "Follow-up for State Regulation 371" (Attachment E) will also be reviewed monthly in the QA meeting held by the facility to ensure ongoing compliance.</p>		

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	<p>(DFM) on 12/18/14 at 1:40 p.m., indicated staff were not to be eating their own personal food in the food preparation areas. She also indicated the Aide should have washed her hands with soap and water after the removal of the gloves.</p> <p>The current 6/24/2008 Eating Food policy provided by the DFM indicated, "No other eating is permitted in the food service area."</p> <p>2. Continued observation on 12/18/14 at 1:40 p.m. there were two long silver pans stacked on top of each other and stored wet. There were three brown silverware bins stored wet and on top of other pans. Further observation indicated there were three square silver pans that were wet and stored on top of each other.</p> <p>Interview with the Food Nutrition Supervisor for the dish room on 12/18/14 at 1:45 p.m., indicated the wet pans and bins should not have been stored on top of each other. She further indicated she had someone new in the dish room.</p> <p>The current 6/24/2008 Dish Machine Operation policy provided by the DFM indicated the drying rack must always be used so that water does not collect in pans.</p>			

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F000425 SS=D	<p>3. Continued observation at the time, indicated there were five boxes stored on the freezer floor. All the boxes were not up on any crates and directly on the floor.</p> <p>Interview with the DFM on 12/18/14 at 2:08 p.m., indicated some of the boxes arrived yesterday and some today, and they were for an outside agency catering party, and were to be picked by them today. She indicated the boxes should not have been stored on the floor.</p> <p>3.1-21(i)(3)</p> <p>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.</p> <p>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.</p>			

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NAME OF PROVIDER OR SUPPLIER MILLER'S HEALTH & REHAB BY MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350			
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	<p>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 expired medications were not given for 1 of 7 residents observed during medication administration pass. (Resident #C)</p> <p>Findings include:</p> <p>On 12/17/14 at 5:59 p.m., RN #1 was observed administering medications to Resident #C. The resident was going to receive one unit of Novolog insulin by the way of a flex pen (insulin pen). The flex pen was dated as being opened on 11/16/14. There was a label on the flex pen to discard 28 days after opening. The RN administered one unit of Novolog insulin to the resident's left upper arm.</p> <p>On 12/19/14 at 10:50 a.m., the medication cart was observed with LPN #1 present. The Novolog flex pen for Resident #C, which had been dated as opened on 11/16/14, remained in the medication cart.</p> <p>Interview with the LPN at the time, indicated the insulin was expired based on the facility's policy and should not be used. The LPN removed the insulin pen</p>	F000425	<p>It is the policy of Miller's Health and Rehab, LaPorte to 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.</p> <p>Resident C: Resident experienced no adverse reactions. All residents receiving insulin are at risk to be affected by the deficient practice. 12/19/15 a medication cart audit was completed to ensure that insulins had date opened and not utilized beyond the recommended expiration date. No other incidences of expired insulin were discovered. All nurses will be in-serviced on or before 1/14/14 the policy for storage of insulin. Insulin is stored in the facility med room refrigerator until vial is opened. The vial/pen is dated when opened and placed in medication cart for use. A list of recommended insulin expiration time frames will be placed in the front of each MAR to serve as a reference for licensed nursing staff. Facility charge nurses will be responsible to assist in continued compliance thru routine observation of cart during medication pass. The unit manager or other designee will be responsible to completed</p>	01/18/2015			

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F000431	<p>from the medication cart and obtained a new insulin pen from the Emergency Drug Kit (EDK).</p> <p>Interview with the Director of Nursing on 12/19/14 at 11:00 a.m., indicated RN #1 should have checked the label on the insulin pen and obtained a new one prior to administering the one unit of insulin to the resident.</p> <p>The facility policy titled "Storage of Medications" was reviewed on 12/19/14 at 10:30 a.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated, "outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy if a current order exists."</p> <p>3.1-25(o)</p> <p>483.60(b), (d), (e)</p>		<p>the "Medication Cart Review"(Attachment C) on each facility medication cart 2 times weekly for 4 weeks, then weekly for 4 weeks, and then biweekly for ongoing basis to monitor continued compliance. 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.</p>		

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SS=D	<p>DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were stored properly for 2 of 3 medication carts on the Fifth floor. (Medication carts #1 and #2)</p>	F000431	It is the policy of Miller's Health and Rehab, LaPorte to store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have	01/18/2015

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	<p>Findings include:</p> <p>1. On 12/17/14 at 5:02 p.m., medication cart #1 was observed to be unlocked. No staff were in the area at this time. The medication cart was located in front of Room 5202. The door to the room was closed at this time.</p> <p>2. On 12/18/14 at 2:00 p.m., there were two pre-filled syringes of normal saline observed on top of medication cart #2. There was no staff in the area at this time.</p> <p>At 2:03 p.m., RN #2 left an intravenous (IV) antibiotic medication on top of the medication cart while she went into Resident #13's room to administer a medication. The medication cart was not in the RN's view while she was in the resident's room.</p> <p>At 3:35 p.m., the medication cart was observed to be unlocked. No staff were in the area at this time.</p> <p>Interview with the Director of Nursing (DON) on 12/19/14 at 9:30 a.m., indicated the medication carts were to be locked when no staff were present. The DON also indicated medications were not be left unattended on top of the medication cart.</p>		<p>access to the keys. Facility medication carts will be locked when not in direct supervision of licensed nursing staff. Medications and other pharmaceuticals will not be left unattended. All residents are at risk to be affected by deficient practices. An all staff in-service will be completed on or before 1/14/15 with licensed nursing staff to review the facility policy for "Storage of Medications" The importance of storing medications and biologicals safely, securely, properly and following the manufacturer's recommendations an only to be accessible only to licensed nursing personnel and pharmacy personnel. The nurse managers will participate in routine walking rounds on various shifts at medication administration times to monitor that nurses are maintaining the security of medications/biologicals at all times. The corrective action will be monitored utilizing the QA tool titled "Quality Care Review" (Attachment A) The tool will be completed daily for 1 week, then 3 times weekly for 3 weeks, weekly for 4 weeks, then monthly by 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 during facility Quality Assurance Meeting to ensure ongoing</p>				

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	<p>The facility policy titled "Medication Administration Procedure" was reviewed on 12/19/14 at 10:30 a.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated the medication cart was to be locked before leaving it.</p> <p>The facility policy titled "Storage of Medications" was reviewed on 12/19/14 at 10:30 a.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated, medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>3.1-25(j)</p>		compliance.		

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and</p>			
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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure hand washing was completed after glove removal and scissors were disinfected after being used in a treatment for 1 of 1 treatments observed and for 1 of 7 residents observed during medication administration. The facility also failed to ensure tooth brushes, wash basins, bed pans, and urinals were stored properly on 2 of 2 units throughout the facility. (Resident #C and the Unit 5 and Unit 6)</p> <p>Findings include:</p> <p>1. On 12/17/14 at 5:57 p.m., RN #1 was observed administering medication to Resident #C. The RN put on a pair of gloves and administered insulin to the resident. After administering the insulin, the resident asked the RN if she would remove the dressing from his fistula on his right upper arm. Dried drainage was observed on the dressing. The RN proceeded to wad up the dressing and place it in her gloved hand. The RN also used the same hand which contained the soiled dressing to grab the resident's insulin pens. The RN then left the room. The dressing was disposed of and the insulin pens were put on the medication cart. The RN then proceeded to remove</p>	F000441	<p>It is the policy of Miller's Health and Rehab, Laporte to maintain an infection control program that is designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. Resident C: Resident remains free from negative outcomes related to deficient practice. RN # 1 has been re-educated on infection control policies and procedures. RN #1 participated in medication pass observation and dressing change return demonstration to ensure infection control maintained during the performed resident care procedures. Re-educated on importance of wiping scissors with alcohol wipe or sanitation wipe after each use. The policy and procedure for "Glove use and Hand-washing" was also reviewed with RN #1. Resident tooth brushes, wash basins, bed pans and urinals will be stored in self contained device in residents room to maintain infection control standards. All residents are at risk to be affected by the deficient practice. All nursing staff will be in-serviced on or before 1/14/15 regarding basic infection control practices and importance of storing resident personal care items in a manner that ensure infection control standards. Each</p>	01/18/2015

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	<p>her gloves.</p> <p>At 6:48 p.m., RN #1 was observed completing a dressing change to the resident's bilateral feet. The RN used her scissors to cut off the Kerlix dressing to both feet. After the treatment was completed at 7:20 p.m., the RN left the room. Her scissors were left on the overbed table in the resident's room. At 7:27 p.m., the RN went back into the resident's room and obtained her scissors. The RN placed the scissors in her pocket without cleaning them.</p> <p>Interview with the Director of Nursing on 12/19/14 at 11:00 a.m., indicated hands were to be washed with soap and water after glove removal and she also indicated the RN should have cleaned her scissors before putting them away.</p> <p>The facility policy titled "Use of Medical Gloves (application and removal)" was reviewed on 12/19/14 at 10:35 a.m. The policy was provided by the Director of Nursing and identified as current. The policy indicated, "gloves should be removed and hands washed with soap and water immediately after glove removal."</p>		<p>staff member will complete a return demonstration of proper hand-washing technique and glove use. The nurse managers will be responsible to make random walking rounds on all shifts during medication administration times to monitor for continued compliance with hand-washing/glove use, 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 new charge nurse performs a return demonstration of proper hand-washing/glove use during medication pass, cleaning of scissors after dressing changes before performing skills independently. The in-service director or other designee will be responsible to complete quarterly competencies with all charge nurses for Medication pass administration and Dressing change procedure to ensure infection control practices are followed. The corrective action will be monitored utilizing the QAtool titled "Quality Care Review" (Attachment A) The tool will be completed daily for 1 week, then 3 times weekly for 3 weeks, weekly for 4 weeks, then monthly by 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</p>		

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	<p>2. The following was observed on Unit 5:</p> <p>a. On 12/15/14 at 3:00 p.m., Room 5203 was observed. There were two pink wash basins stored on the bathroom counter uncovered.</p> <p>b. On 12/15/14 at 3:13 p.m., Room 5223 was observed. There was a bed pan stored on top of the toilet seat upside down and uncovered.</p> <p>3. The following was observed on Unit 6:</p> <p>a. On 12/16/14 at 8:58 a.m., Room 6237 was observed. There was a toothbrush noted on the silver shelf under the mirror in the bathroom, the bristles were face down touching the shelf.</p> <p>b. On 12/16/14 at 9:15 a.m., Room 6229 was observed. There was a toothbrush stored on the counter in the bathroom, the bristles were touching the counter.</p> <p>c. On 12/16/14 at 9:38 a.m., Room 6221 was observed. There was a pink wash</p>		<p>beriewed monthly during facility quality assurance meeting to ensure ongoing compliance.</p>	

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	<p>basin stored on the bathroom counter uncovered. There was also a urinal in a bag hanging from the toilet, the top of the cap on the urinal was exposed.</p> <p>d. On 12/16/14 at 10:25 a.m., Room 6236 was observed. There was a pink wash basin stored on the bathroom counter uncovered.</p> <p>Interview with the Unit Manager on 12/19/2014 at 9:29 a.m., indicated the above items were not stored properly.</p> <p>Interview with the Administrator on 12/19/14 at 1:00 p.m., indicated there was not a facility policy related to the proper storage of the above items.</p> <p>3.1-18(a) 3.1-18(l)</p>			
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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the environment was clean and in good repair related to urine odors, holes in walls, green and white substances on bathroom faucets, dusty bathroom ceiling vents, chipped wood on dressers, and marred doors and walls for 2 of 2 units observed. (Unit 5 and Unit 6)</p> <p>Findings include:</p> <p>The Environmental tour was completed on 12/19/14 at 9:00 a.m., with the Maintenance Director.</p> <p>1. The following was observed on Unit 5:</p> <p>a. Room 5236-There was a stale urine odor in the bathroom.</p> <p>b. Room 5203-There was chipped wood on the corner of the dresser. There were holes in the wall near the bathroom door and behind the bed.</p>	F000465	<p>It is the policy of Miller's Health and Rehab, LaPorte to provide a safe, functional, sanitary, and comfortable environment for residents, staff and public. All issues identified during the environmental tour will be corrected on or before 1/18/15. Resident rooms 5205, 5206, and 5219 had all of the faucets cleaned to remove the green/white substance from them. Rooms 5203, 5222, and 5223 had all of the holes in the wall filled and repaired. Resident rooms 5236 and 6233 were deep cleaned and removed the stale odor from the room. Resident rooms 5203, 5222, 6225, and 6226 had the doors, ceiling vent, dressers and night stands repaired and cleaned. 10 of 46 residents in the facility have the potential to be affected by these findings. On 1/12/15 an environmental walk through audit will be completed of all resident rooms to address any other areas that have the potential to affect other residents. Any findings will be repaired immediately.</p>	01/18/2015

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	<p>c. Room 5205-There was a green substance on the bathroom faucet. There was a white substance along the wall in front of the bed.</p> <p>d. Room 5206-There was a green substance on the bathroom faucet.</p> <p>e. Room 5219-There was a white substance on the bathroom faucet.</p> <p>f. Room 5222-There was a hole in the wall under the call system. The night stand was chipped on the corner.</p> <p>g. Room 5223-There were holes in the wall near the bathroom and near the bed.</p> <p>2. The following was observed on Unit 6:</p> <p>a. Room 6233-There was a stale urine odor in the room and bathroom.</p> <p>b. Room 6225-The base of the door was scratched and marred.</p> <p>c. Room 6226-The bathroom ceiling vent was dusty.</p> <p>Interview at the time with the Maintenance Director indicated the above items were in need of cleaning and/or repair.</p>		<p>To ensure that this practice is prevented from occurring again the maintenance supervisor and or designee will conduct daily rounds using the "Environmental Quality Review" (Attachment D) 2 rooms daily for 4 weeks, then 2 rooms weekly for 4 weeks, then 4 rooms monthly to monitor continued compliance. All staff will be educated on or before 1/18/15 to ensure understanding of maintaining a clean and hazard free environment of the facility. The "Environmental Quality Review" (Attachment D) will be reviewed monthly as part of the QA program for further compliance.</p>				

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NAME OF PROVIDER OR SUPPLIER MILLER'S HEALTH & REHAB BY MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350		
(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	
	3.1-19(f)				