

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  04/20/2015
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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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F 000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00171033.</p> <p>Complaint IN00171033-Substantiated. Federal/State deficiencies related to the allegations were cited at F166, F225, F226, F241, F282, and F465.</p> <p>Survey dates: April 19 &amp; 20, 2015</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Census by bed type: SNF: 13 SNF/NF: 61 Total: 74</p> <p>Census payor type: Medicare: 12 Medicaid: 50 Other: 12 Total: 74</p> <p>Sample: 6</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.-3.1.</p>	F 000		
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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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F 166 SS=D Bldg. 00	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on interview and record review, the facility failed to ensure a resident's family member who had voiced a grievance, in regard to the resident's care was kept informed of the progress toward</p>	F 166	<p><b>F Tag 166 Right to Prompt Efforts to Resolve Grievances</b></p> <p>It is the policy of Miller's Merry Manor Hobart to ensure the resident's has the right to prompt efforts by the facility to resolve grievances the resident may</p>	05/07/2015

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	<p>the resolution to the grievance, for 1 of 5 residents reviewed in a total sample of 5. (Resident #B)</p> <p>Finding includes:</p> <p>During an interview with Resident #B's Responsible Party, on 04/20/15 at 11:10 a.m., she indicated she had come into the facility on 04/03/15 at around 10:30 p.m. and found the resident soaked with urine, the sheets the resident was lying on was soaked with urine and the head of the bed had been left flat. She indicated the Nurse had informed her she had just checked the resident and the CNA on duty had indicated there had been a call off and she was running behind. Resident #B's Responsible Party indicated she had voiced a grievance but had came into the facility a few days later and found her mother sliding from her wheelchair and soaked with urine again.</p> <p>A Concern Form, dated 04/07/15, no time documented, indicated the Responsible Party had voiced a grievance to LPN #1. The form indicated, "...On Good Friday, she came in at about 10:30. Her mother was soaked from head to toe and her head was low on the bed. She had to change her mothers (sic) bed linen. There was (sic) 4 pads on the bed soaked." The Plan of Action, indicated,</p>		<p>have, including those with respect to the behavior of other residents. <b>Resident B:</b> Follow up call made to daughter to review plan of care and she reported that everything was good. No other concerns, satisfied with plan of care. <i>All residents in the facility have the potential to be affected by this deficient practice.</i> All staff will be in-serviced on the facility policy "Grievance Procedure" and trained on how to receive grievance voiced by residents/responsible party on or before 5/7/15. Upon admission the social services designee will be responsible to inform residents/responsible party of their right to voice grievances with respect to treatment received, as well as, a lack of treatment received during their stay in the facility. Residents will be informed of the oral and written method for communicating grievances/concerns to staff. Social Services will assist with collecting grievances and tracking those grievances for timely and acceptable response. The designated staff will be notified within 24hours of the submitted grievance and logged on facility concern form to ensure proper documentation of both the concern, plan for correction, and the resident/responsible party satisfaction with resolution for grievance. The Social Services Director or other designee will be</p>				

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	<p>"Staff will do hourly checks to make sure this doesn't happen again..." The follow up with concerned party, dated 04/08/15, indicated, "Outcome Spoke with (Responsible Party Name) about our plan." The form was signed by the Administrator.</p> <p>Resident #B's record was reviewed on 04/20/15 at 9:20 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and diabetes mellitus.</p> <p>The Significant Change Minimum Data Set assessment, dated 02/26/15, indicated the resident had a long term memory problem, severely impaired decision making skills, required extensive assistance of two or more staff for bed mobility, was dependent for dressing, hygiene, and bathing, and was always incontinent of bowel and bladder.</p> <p>During an interview on 04/20/15 at 2:30 p.m., the Administrator indicated she had never followed up with the Responsible Party to see if the plan of action had been successful.</p> <p>A facility policy, titled, "Grievance Procedure", dated 02/22/13, and received from the Administrator as current, indicated, "...Follow up with the involved</p>		<p>responsible to complete the QA tracking tool "Concern Form" (Attachment E) with each resident/responsible party grievance to ensure all components of a thorough concern investigation is completed to the resident/responsible party satisfaction. The tool will be completed prior to the Administrator signing off the form as completed for the next 6months. Once the form is complete the QA tracking tool "Grievance and Concern Log" (Attachment F) will be completed and reviewed monthly at the facility QA meeting. Any areas not completed per policy will be corrected/investigated and then logged on a QA tracking log. The QA tracking logs will be brought to the monthly QA meeting for review and to monitor for ongoing compliance.</p>		

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F 225 SS=D Bldg. 00	<p>party will be completed until the concern is resolved to the satisfaction of the resident and/or involved party..."</p> <p>This Federal Tag relates to Complaint IN00171033.</p> <p>3.1-7(a)(2)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p>			

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	<p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview the facility failed to timely report an allegation of abuse to the Administrator of the facility and to the Indiana State Department of Health (ISDH), related to a resident's allegation of verbal and mental abuse, for 1 of 3 residents reviewed for abuse in a total sample of 5. (Resident #F)</p> <p>Findings include:</p> <p>During an interview on 04/19/15 at 6:12 p.m., Resident #F's family member indicated the staff call the resident names of, "pork chop or porky" and had informed the resident she was, "too big to move". The family member indicated the resident had reported the abuse to the facility.</p>	F 225	<p><b>F Tag 225 Investigate/Report Allegations/Individuals</b> It is the policy of Miller's Merry Manor, Hobart to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility will maintain evidence that all alleged violations are thoroughly investigated, to prevent further potential abuse while the investigation is in progress.</p> <p><b>Resident F:</b> Any future allegation of abuse will be immediately communicated to facility administrator or other designee and facility policy/procedure implemented at the time of the</p>	05/07/2015

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	<p>During an interview on 04/19/15 at 6:38 p.m., Resident #F indicated she had reported the name calling to Social Service #2. She indicated, CNA #3 had been laughing and called her pork chop and porky on Friday (April 17, 2015) during her morning care. Resident #F indicated when she asked CNA #4 to do care, CNA #4 said she was just too heavy to move. Resident #F indicated she had also reported this to Social Service #2. Resident #F indicated she felt the statements were verbal and mental abuse.</p> <p>During an interview on 04/19/15 at 6:51 p.m. Social Service #2 indicated the resident had reported the allegation to her on Friday (04/17/15). Social Service #2 indicated she had not reported the allegation to the Administrator nor the Director of Nursing because they had already left for the day. Social Service #2 indicated she should have reported the allegation to the Director of Nursing. Social Service #2 indicated the ISDH had not been notified of the allegation of abuse.</p> <p>Resident #F's record was reviewed on 04/20/15 at 12:45 p.m. The resident's diagnoses included, but were not limited to, multiple sclerosis and hypertension.</p>		<p><i>initial report. The ISDH was notified by written follow up report procedure regarding the outcome of investigation on 4/21 /15. On 4/19/15 when state surveyor reported allegation to administrator the facility immediately suspended C.N.A. # 3 and C.N.A. # 4 to prevent further potential allegation of abuse while investigation in progress. On 4/20/15 Social Services # 2 was re-educated on facility policies "Abuse Prohibition, Reporting, and Investigation" and "Incident Reporting to the ISDH" and a copy placed in employee file. All residents are at risk to be affected by the deficient practice. All staff were in-serviced on the "Incident Reporting to the ISDH" (Attachment A) and "Abuse Prohibition, Reporting, and Investigation" (Attachment B) by 5/7/15. All staff are trained on the facility policy and procedures for "Abuse Prohibition, Reporting, and Investigation" upon hire and at least every 6 months thereafter to ensure ongoing compliance and knowledge. The facility staff will be educated to report all allegations of abuse, unusual occurrences, to the charge nurse and the charge nurse will immediately report to the administrator or other designee. An investigation will be immediately initiated and directed by the administrator or designee and a detailed report will be</i></p>				

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F 226 SS=D Bldg. 00	<p>The Annual Minimum Data Set assessment, dated 04/02/15, indicated the resident's cognition was intact and was dependent on two staff members for transfers, toileting, and bathing and one staff member for dressing and hygiene.</p> <p>This Federal Tag relates to Complaint IN00171033.</p> <p>3.1-28 (c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not immediately reporting an allegation of abuse to the Administrator of the facility and the Indiana State Department of</p>	F 226	<p>forwarded to the ISDH within 5 days. The investigation will be summarized, signed, and dated and kept as evidence of the facility's investigation by the administrator or other designee. The "Abuse Investigation Worksheet" (Attachment C) will be utilized by the administrator or other designee with each abuse allegation to ensure all components of a thorough investigation is completed per facility policy. The tool will be completed prior to submitting the final 5day summary of investigation to the ISDH for the next 6months. Any areas not completed per policy will be corrected/investigated and then logged on a QA tracking log. The QA tracking logs will be brought to the monthly QA meeting for review and to monitor for ongoing compliance.</p> <p><b>F-Tag 226 Develop/Implement Abuse/Neglect, Etc Policies</b> It is the policy of Millers Merry Manor, Hobart to maintain and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation</p>	05/07/2015	

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	<p>Health (ISDH), and protecting other residents from the potential of abuse for 1 of 3 residents reviewed for abuse in a total sample of 5. (Residents #F)</p> <p>Finding includes:</p> <p>A facility policy, titled, "Abuse Prohibition, Reporting, and Investigation", dated 02/13, and received from the Director of Nursing as Current, indicated, "...ensures that all alleged violations...are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)...must prevent further potential abuse while the investigation is in progress...All reports of alleged abuse...must be reported to the Administrator immediately...Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until the investigation is completed..."</p> <p>During an interview on 04/19/15 at 6:12 p.m., Resident #F's family member indicated the staff call the resident names of, "pork chop or porky" and had informed the resident she was, "too big to move". The family member indicated the resident had reported the abuse to the</p>		<p>of resident property. <b>Resident F:</b> Any future allegation of abuse will be immediately communicated to facility administrator or other designee and facility policy/procedure implemented at the time of the initial report. The ISDH was notified by written follow up report procedure regarding the outcome of investigation on 4/21/15. On 4/19/15 when state surveyor reported allegation to administrator the facility immediately suspended C.N.A. # 3 and C.N.A. # 4 to prevent further potential allegation of abuse while investigation in progress. On 4/20/15 Social Services # 2 was re-educated on facility policies "Abuse Prohibition, Reporting, and Investigation" and "Incident Reporting to the ISDH" and a copy placed in employee file. All residents are at risk to be affected by the deficient practice. All staff were in-serviced on the "Incident Reporting to the ISDH" (Attachment A) and "Abuse Prohibition, Reporting, and Investigation" (Attachment B) by 5/7/15. All staff are trained on the facility policy and procedures for "Abuse Prohibition, Reporting, and Investigation" upon hire and at least every 6 months thereafter to ensure ongoing compliance and knowledge. The facility staff will be educated to report all allegations of abuse, unusual occurrences, to the charge nurse</p>				

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	<p>facility.</p> <p>During an interview on 04/19/15 at 6:38 p.m., Resident #F indicated she had reported the name calling to Social Service #2. She indicated, CNA #3 had been laughing and called her pork chop and porky on Friday (April 17, 2015) during her morning care. Resident #F indicated when she asked CNA #4 to do care, CNA #4 said she was just too heavy to move. Resident #F indicated she had also reported this to Social Service #2. Resident #F indicated she felt the statements were verbal and mental abuse.</p> <p>During an interview on 04/19/15 at 6:51 p.m. Social Service #2 indicated the resident had reported the allegation to her on Friday (04/17/15). Social Service #2 indicated she had not reported the allegation to the Administrator nor the Director of Nursing because they had already left for the day. Social Service #2 indicated she should have reported the allegation to the Director of Nursing. Social Service #2 indicated the ISDH had not been notified of the allegation of abuse. Social Service #2 indicated CNA #3 and CNA #4 had not been removed from the building after the allegation of abuse had been reported.</p> <p>During interview on 04/19/15 at 6:55</p>		<p>and the charge nurse will immediately report to the administrator or other designee. An investigation will be immediately initiated and directed by the administrator or designee and a detailed report will be forwarded to the ISDH within 5 days. The investigation will be summarized, signed, and dated and kept as evidence of the facility's investigation by the administrator or other designee. The "Abuse Investigation Worksheet" (Attachment C) will be utilized by the administrator or other designee with each abuse allegation to ensure all components of a thorough investigation is completed per facility policy. The tool will be completed prior to submitting the final 5day summary of investigation to the ISDH for the next 6months. Any areas not completed per policy will be corrected/investigated and then logged on a QA tracking log. The QA tracking logs will be brought to the monthly QA meeting for review and to monitor for ongoing compliance.</p>				

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	<p>p.m., the Administrator indicated the staff were supposed to call her when there was an allegation of abuse. She indicated she had not been called.</p> <p>During an interview on 04/20/15 at 2:30 p.m., the Administrator indicated CNA #3 had finished her shift until 2 p.m. on 04/17/15 and CNA #4 had worked the 2 p.m. to 10 p.m. shift on 04/17/15 and the 6 a.m. to 2 p.m. shift on 04/18/15 and 04/19/15.</p> <p>Resident #F's record was reviewed on 04/20/15 at 12:45 p.m. The resident's diagnoses included, but were not limited to, multiple sclerosis and hypertension.</p> <p>The Annual Minimum Data Set assessment, dated 04/02/15, indicated the resident's cognition was intact and was dependent on two staff members for transfers, toileting, and bathing and one staff member for dressing and hygiene.</p> <p>This Federal Tag relates to Complaint IN00171033.</p> <p>3.1-28(a)</p>			

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F 241 SS=D Bldg. 00	<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 record review and interview, the facility failed to ensure a resident was treated with dignity from staff members, for 1 of 3 residents reviewed for abuse in a total sample of 5. (Resident #F)</p> <p>Finding Includes:</p> <p>During an interview on 04/19/15 at 6:12 p.m., Resident #F's family member indicated the staff call the resident names of, "pork chop or porky" and had informed the resident she was, "too big to move". The family member indicated the resident had reported the abuse to the facility.</p> <p>During an interview on 04/19/15 at 6:38 p.m., Resident #F indicated she had reported the name calling to Social Service #2. She indicated, CNA #3 had been laughing and called her pork chop and porky on Friday (April 17, 2015) during her morning care. Resident #F indicated when she asked CNA #4 to do</p>	F 241	<p><b>F241 Dignity and Respect of Individuality:</b> 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.</p> <p><b>Resident # F:</b> The CNA's #3 and #4 were suspended pending the investigation. Upon return Aides were educated on resident's right to be treated with dignity in regards to calling resident's by their proper names and not a nickname. <i>All residents in the facility have the potential to be affected by this deficient practice.</i> The facility educated all staff on addressing residents by their names and not nicknames on 4/22/15. Upon admission, quarterly, and with significant changes in status the social services director is responsible to review resident specific preferences for care. Each resident's plan of care includes individualized resident plan of care indicating the resident preferences. The nurse aide assignment sheet will be updated as needed to reflect specific resident preferences and will</p>	05/07/2015			

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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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	<p>care, CNA #4 said she was just too heavy to move. Resident #F indicated she had also reported this to Social Service #2. Resident #F indicated she felt the statements were verbal and mental abuse.</p> <p>Resident #F's record was reviewed on 04/20/15 at 12:45 p.m. The resident's diagnoses included, but were not limited to, multiple sclerosis and hypertension.</p> <p>The Annual Minimum Data Set assessment, dated 04/02/15, indicated the resident's cognition was intact and was dependent on two staff members for transfers, toileting, and bathing and one staff member for dressing and hygiene.</p> <p>An investigation of the allegation, dated 04/19/15 at 8:05 a.m., indicated CNA #3 had been interviewed by telephone. The interview indicated the CNA could not remember why she went in the resident's room. CNA #3 indicated she had called the resident "Porky" and the resident responded with, "nothing Fatty". CNA #3 then indicated the resident had told her she did not like being called Porky and CNA #3 apologized.</p> <p>An investigation of the allegation, dated 04/20/15 at 9:25 a.m., indicated CNA #4 was interviewed by telephone. The interview indicated the resident had</p>		<p>serve as the communication tool for staff to be aware of care preferences. The administrator, social service designee, and nurse managers will be responsible to participate in routine walking rounds of the facility; 3 times a week for 2 weeks and 2 times a week thereafter; on varying shifts and at different times to monitor that residents are being addressed by their names. The corrective action will be monitored utilizing the QA tool "Observation Care Review" (Attachment D). 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.</p>		

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F 282 SS=D Bldg. 00	<p>asked her to put Vaseline on her thighs and CNA #4 rolled her over and then said she was too heavy for her. CNA #4 indicated the resident had said the comment was not nice and CNA #4 then apologized to the resident and indicated she was not referring to the resident's size, but was talking about herself being skinny.</p> <p>This Federal Tag relates to Complaint IN00171033.</p> <p>3.1-3(t)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to follow a</p>	F 282	<b>F-Tag 282 Services by Qualified Persons/Per Care Plan:</b> It is the policy of Miller's	05/07/2015

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	<p>resident's plan of care, related to assistance with activities of daily living (ADL's) for 1 of 3 resident reviewed for ADL's in a total sample of 5. (Resident #B)</p> <p>Finding includes:</p> <p>During an observation, on 04/20/15 at 12:50 p.m., CNA #5 and CNA #6 transferred Resident #B with a mechanical lift from the chair to the bed. After the resident was placed on to the bed, CNA #6 left the room. CNA #5 then began to check the resident for incontinence. The resident was grabbing out at CNA #5 and attempting to pull the pants up once CNA #5 had lowered the pants to remove the brief. CNA #5 indicated the resident sometimes became combative with care.</p> <p>CNA #5 continued to change the resident's brief, having to turn the resident from side to side frequently to remove the pad and the brief and to place a clean brief on the resident. While continually turning the resident from side to side, the resident was pushing CNA #5's hands away and continued to attempt to pull up the pants. CNA #5 indicated the CNA's carry care cards to inform them how to care for the resident. CNA #5 indicated sometimes the resident</p>		<p>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 bruises, side rails, oral care and insulin.</p> <p><b>Resident B:</b> Assessment was completed; no findings. CNA #5 was immediately in-serviced on following CNA care card. Two staff members will be present when providing care. <i>All residents are at risk to be affected by the deficient practice.</i> The facility C.N.A. care cards include communication regarding the number of care givers required by the individual resident's plan of care. The care cards are updated with significant change in status and a minimum of weekly. The nurse managers and charge nurses utilize the care cards when making walking rounds on unit to ensure nurse aides are delivering care per plan of care. All nursing staff were in-serviced on 4/22/15 regarding the importance of following the care cards to deliver care to the residents. The administrator, social services designee, and nurse managers will be responsible to participate in routine walking rounds of the facility; 3x a week for 2 weeks and 2x a week thereafter; on varying shifts and at different times to monitor that resident's are receiving care per HCP as indicated on the resident care</p>		

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	<p>required two staff but (CNA #5) was able to do it with one.</p> <p>The Northwest Pocket Sheet (care card), dated 04/07/15, indicated Resident #B required two assistance for care.</p> <p>Resident #B's record was reviewed on 04/20/15 at 9:20 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and diabetes mellitus.</p> <p>The Significant Change Minimum Data Set assessment, dated 02/26/15, indicated the resident had a long term memory problem, severely impaired decision making skills, required extensive assistance of two or more staff for bed mobility, was dependent on two staff members for toileting, hygiene, and bathing, and was always incontinent of bowel and bladder.</p> <p>During an interview on 04/20/15 at 2:35 p.m., the Director of Nursing indicated the resident required two staff members for care due to combativeness.</p> <p>This Federal Tag relates to Complaint IN00171033.</p> <p>3.1-35(g)(2)</p>		<p>cards. The corrective action will be monitored utilizing the QA tool "Observation Care Review" (Attachment D). The tool will be completed daily x1 week, then 3x weekly for 3 weeks, 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.</p>		

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F 465 SS=D Bldg. 00	<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, record review, and interview, the facility failed to ensure a resident's room was clean and sanitary, related to a soiled sheet left on a bed, for 1 of 4 resident beds observed for cleanliness of linens. (Resident #B)</p> <p>Finding includes:</p> <p>During an observation on 04/20/15 at 8:20 a.m., CNA #5 had just completed incontinence care on Resident #B. There was a clear plastic bag which contained a soiled brief in CNA #5 hand. The resident remained in bed. CNA #5 indicated after the resident had breakfast the resident would be transferred to the chair.</p>	F 465	<p><b>F-Tag 465:</b> <b>Safe/Functional/Sanitary/Comfortable Environment</b> It is the policy of Miller's Merry Manor, Hobart to provide a safe and sanitary environment. <b>Resident B:</b> Linen was stripped from bed and bed disinfected. <i>All residents in the facility have the potential to be affected by these findings.</i> A walk through audit was completed to address any other areas that have the potential to affect other residents on or before 4/21/15. An all staff in-service was held on or before 5/7/15 to review the importance of maintaining a clean and sanitary environment for the residents in the facility. Staff advised that soiled linens shall be removed promptly upon discovery. The administrator, social service designee, and nurse managers</p>	05/07/2015
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	<p>During an observation on 04/20/15 at 8:50 a.m., CNA #5 and CNA #7 were observed transferring Resident #B, who was now dressed for the day, with the mechanical lift from the bed to the chair. After the resident was transferred from the bed to the chair, the CNA's left the room. No linens were removed from the room.</p> <p>During an observation on 04/20/15 at 11:30 a.m., with Resident #B's Responsible Party present, there was a long oblong yellow/brown tinged stain on the bottom sheet, which remained on the resident's bed. There were also light brown spots on the bottom sheet. The sheet on the bed had a urine odor present. Resident #B's Responsible Party indicated the cover, which was damp had been covering the stain.</p> <p>During an interview on 04/20/15 at 11:35 a.m., the Director of Nursing indicated the odor was a, "sweet smell" and then indicated it could be feeding from the gastrostomy tube.</p> <p>This Federal Tag relates to Complaint IN00171033.</p> <p>3.1-19(f)</p>		<p>will be responsible to participate in routine walking rounds of the facility; 3 times a week for 2 weeks and 2 times a week thereafter; on varying shifts and at different times to monitor that residents are being addressed by their names. The corrective action will be monitored utilizing the QA tool "Observation Care Review" (Attachment D). 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. To ensure that this does not re-occur housekeeping supervisor and or designee will conduct daily rounds using the "Room Preparation Checklist" (Attachment E) three rooms, per unit daily for four weeks then two rooms, per unit weekly thereafter. Nursing staff re-inserviced on cleaning procedures and removal of soiled linen on 4/22/2015. 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.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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