STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155173		05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	505 N BRADNER AVE MARION, IN 46952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 4, 5, 6, 9, 10, 11 and 12, 2016 Facility number: 000089 Provider number: 155173 AIM number: 100287769 Census bed type: SNF/NF: 86 SNF: 8 Total: 94 Census payor type: Medicare: 15 Medicaid: 68 Other: 11 Total: 94 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on May 16, 2016.	F 0000	Please accept our plan of correction for the alleged deficiencies stated in this CMS 2567. The facility respectfully requests paper compliance for the alleged deficiencies. The facility has requested informal dispute resolutions for two F tags 279, and 314. The facility has attached documents attached for the IDR. If you have any questions, please call us at 765 662 3981.	
F 0248	483.15(f)(1)			

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

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

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SS=D Bldg. 00	ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure an activities program was in place for cognitively impaired residents for 2 of 3 residents reviewed for activities (Residents #17 and #66). Findings include: 1. On 5/4/16 at 2:18 p.m., Resident #17 was in bed asleep. On 5/5/16 at 10:56 a.m., Resident #17 was asleep in bed. The activity schedule outside of the activity room indicated "Five Alive" sensory group was scheduled for 10:30 a.m. On 5/5/16 at 2:57 p.m., Resident #17 was asleep in bed. On 5/6/16 at 9:46 a.m., Resident #17 was asleep in bed. A ball toss activity was taking place in the main dining room. On 5/6/16 at 1:19 p.m., Resident #17 was seated in her wheelchair in the hallway,	F 0248	It is the policy of Miller's Merry Manor to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident. Residents #17 and 66 have been offered/placed in activities that are appropriate for their cognition and level of functioning. Each resident will be assisted and encouraged to participate in activities at their level of functioning. Resident #17 and 66 have been participating in other activities in addition to listening to music and a variety of other activities for the resident. All cognitively impaired residents have the potential to be affected by this alleged deficient practice. The Activity Director completed a full audit on those residents who have impaired cognition. Each resident will be assisted and encouraged to participate in activities at their level of functioning. Activity staff were inserviced on the above on 5/20/16 during the all staff mandatory inservice. Activity staff will be re educated on the above again by June 11 2016 A	06/11/2016

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	near the TV lounge. On 5/6/16 at 2:36 p.m., Resident #17 was seated in her wheelchair in her room. The Mother's Day Celebration was taking place in the main dining room. On 5/6/16 at 3:21 p.m., Resident #17 remained seated in her wheelchair in her room. A political show was on the TV with no sound. The resident was pulling at her shirt. On 5/10/16 at 10:59 a.m., Resident #17 was seated in her wheelchair in the hallway, just outside of the TV lounge. A bible study was taking place in the lounge area. On 5/10/16 at 1:07 p.m., Resident #17 was being propelled in her wheelchair from the dining room to her room. On 5/10/16 at 3:22 p.m., Resident #17 was in bed. Root beer floats were being served in the main dining room while a DJ played music. On 5/11/16 at 9:39 a.m., Resident #17 was in bed asleep. On 5/11/16 11:18 a.m., Resident #17 was propelled to the dining room for lunch and was seated at the table.		restructured "Life enrichmentactivity program" has been developed which provides activities for all levels of cognition. There is a specific focus on activities for residents who have moderate and severe cognitive impairments. There are a variety of activities which reach the resident at their level of functioning. These residents will be identified based on BIMS SCORE, Activity Assessments, and MDS assessments. These activities will be in small groups with the length of activity to be appropriate for the resident's attention span. If residents are unable to stay awake and alert they will be allowed to return to their room to rest. The resident's participation will be evaluated routinely and changes will be made as necessary. The Activity Department will be educated on appropriate activities for resident's level of cognition and function. This education will be given by the corporate consultant by June 11th 2016. The QA tool titled "Life Enrichment for Cognitively Impaired Residents" (Attachment A) has been developed. It will be completed weekly X8 weeks then monthly thereafter. Any identified issues will be addressed immediately. Concerns/Issues will be logged on the "Quality Improvement Summary Log" (Attachment B) and reviewed/revised monthly in the	

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	On 5/11/16 at 2:40 p.m., Resident #17 was in bed. A Harpist was playing in the lobby, with a cookie and punch reception being served by facility staff. On 5/10/16 at 1:35 p.m., CNA #31 indicated Resident #17 was laid back down after meals. She also indicated residents had tv programming preferences written on papers near their TVs. Observation of Resident #17's card at that time indicated she enjoyed 50's & 60's music and gospel music. It further indicated she enjoyed watching game shows, religious programming, and the news. Review of an Activity Assessment, dated 3/4/16, indicated Resident #17 participated in group activities including, but not limited to, sensory groups, music, exercise, refreshments, and special events , but was mostly passive in her participation. The assessment further indicated Resident #17 enjoyed watching the TV in the lounge. Resident #17 had a current care plan problem of benefiting from increased socialization/stimulation through activity involvement due to cognitive impairments, minimal verbalization, and not self-initiating activity. The careplan		facility QA Meeting. Date of completion: 6/11/2016	

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	indicated Resident #17 enjoyed animals and pet visitors, enjoyed listening to music, and attending religious services. It further indicated the resident needed assistance to and from all activities. A Social Service Assessment, dated 2/29/16, indicated Resident #17 attended scheduled activities and would sit in the lounge at times to watch tv for stimulation. It further indicated she always seemed to be in good spirits as evidenced by reaching out, patting, and kissing staff when they worked with her and she would smile and seem to enjoy tactile hand holding and hugs. 2. On 5/4/16 at 11:14 a.m., Resident #66 was in bed sleeping. On 5/4/16 at 2:20 p.m., Resident #66 was in bed, laying with her back to the door. "Free Form Art" was taking place in the activity room. On 5/5/16 at 9:19 a.m., Resident #66 was in bed awake. Residents were gathering in the main dining room for "Morning Stretch" exercise. On 5/5/16 at 1:09 p.m., Resident #66 was seated in her wheelchair in her room with her head down and the TV off.			

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	On 5/6/16 at 9:46 a.m., Resident #66 was asleep in bed. A ball toss activity was taking place in the main dining room. On 5/6/16 at 1:20 p.m., Resident #66 was seated in her wheelchair in her room. The TV was on a daytime talkshow discussing a topic of children being molested by mother's boyfriends, polygraph tests, and a woman arguing whether her boyfriend had showered with her minor daughter. On 5/6/16 beginning at 2:37 p.m., Resident #66 was seated in the main dining room during the Mother's Day Celebration with her head down in her left hand and her eyes closed. The resident raised her head to drink a cup of punch and placed her head back down. On 5/9/16 at 10:40 a.m., Resident #66 was in bed. A group was gathered at the activity table with newspapers. The activity calendar on the wall outside the door indicated "Coffee/News" was at 10:00 a.m. and "Five Alive" was at 10:45 a.m. On 5/10/16 at 10:01 a.m., Resident #66 was in bed, with the room dark. The "Coffee/News" group was gathering in the activity room.			

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	On 5/10/16 at 11:00 a.m., Resident #66 was seated in her wheelchair just outside of the TV lounge. A bible study discussion was taking place in the lounge with two visitors and two residents. On 5/10/16 at 1:02 p.m., Resident #66 was seated in her wheelchair in her room. The TV was on a daytime talk show about a woman with "substitute husbands". On 5/10/16 at 3:21 p.m., Resident #66 was asleep in bed. Root beer floats were being served in the main dining room, with a DJ playing music. On 5/11/16 at 9:20 a.m., Resident #66 was in bed awake, looking around the room. A group was gathering in the main dining room for "Morning Stretch". On 5/11/16 at 11:15 a.m., Resident #66 was seated in her wheelchair in the hallway across from her room. Her head was resting in her left hand and her eyes were open. On 5/11/16 at 2:40 p.m., Resident #66 was in bed. A Harpist was playing in the lobby with a cookie and punch reception being served by facility staff. On 5/10/16 at 1:35 p.m., CNA #31			

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	indicated Resident #66 was laid back down after meals. She also indicated residents had tv programming preferences written on papers near their TVs. Observation of Resident #66's card at that time indicated she enjoyed 50's & 60's music, gospel, and country-western music. It further indicated she enjoyed watching old game shows and the news. An Activity Assessment, dated 3/9/16, indicated Resident #66 did not have any health conditions preventing her from coming out of her room for activities and she required assistance to and from activities. The assessment further indicated the resident actively participated in, but not limited to, sensory group, mealtime music, cornhole, and exercise. Resident #66 had a current careplan problem of benefiting from increased socialization/stimulation through activities involvement due to cognitive impairment and wheelchair mobility. Interventions indicated it was important to Resident #66 to do things with groups of people including, but not limited to, toss games, newspaper group, and musical entertainers. The careplan also indicated it was important to Resident #66 to watch TV.			

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	Review of an Activity Documentation report, dated April 2016, indicated Resident #66 had attended activities programs on 13 of 30 days, including, but not limited to, four sensory groups, three special events, and three music activities with active participation, as well as two exercise activities with passive participation. Review of an Activity Documentation report, dated May 2016, indicated Resident #66 had attended and participated in a music activity on 5 of 11 days as of May 11, 2016. During an interview, on 5/10/16 at 3:29 p.m., the Activities Director indicated neither Resident #17, nor Resident #66, received 1:1 visits due to the residents participating in lunchtime music. During an interview, on 5/12/16 at 9:09 a.m., the Assistant Activities Director (AAD) indicated if Resident #17 was up in her chair, then she would attend music or sensory group at times. He indicated she was unable to verbalize or actively participate in activities. He also indicated Resident #66 had been staying in bed a lot over the past month and a half. He further indicated she would attend music or sensory group if she was up in her wheelchair, but no			

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	modifications had been made in her activities plan during this time. When questioned about the resident's documented activities participation for May 2016, he indicated "music" meant music being played at mealtime. He indicated if the resident was able to clap their hands or state they enjoyed the music, they were documented as having been an active participant. During an interview, on 5/12/16 at 10:00 a.m., the Activities Director (AD) indicated she played the piano at lunchtime throughout the week for approximately 30 minutes. She indicated a lot of the residents would tell her how much they liked it, but she could not confirm if the music was cognitively stimulating to residents with a cognitive deficit. She also indicated she thought that maybe Resident #66 attended sensory group and had updated documentation reflecting her attendance. She further indicated the TV cards were a new system the facility was implementing, but she had not yet followed up with whether staff was utilizing them. Review of a policy, titled "Life Enrichment Program Guidelines", dated 10/3/13, and provided by the AD on 5/12/16 at 10:27 a.m., indicated the			

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	following: "...1. PURPOSE: A. To enhance the lives of our residents through activity involvement...2. A. Evaluate the level of functioning for current population. Using the "levels of Dementia" guide sheet. B. Offer at least 2 activities daily for each of the 3 groups...III. Level 1/2 (these are your lowest functioning typically the ones who sleep during activities- they need sensory stem [sic]) a. Sensory stem [sic]- daily before lunch and supper- this will wake them up and stimulate the appetite...b. Musical programs c. Spiritual activities d. Gross Motor movement exercises- slow repetitive movements i.e. repetitively clapping hands to music, etc. at least 2 times a week...." 3.1-33(a)			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services			

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	that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, interview, and record review, the facility failed to develop a careplan for a pressure ulcer in a timely manner for 1 of 25 residents whose careplans were reviewed (Resident #17). Findings include: An observation of wound care for Resident #17, beginning on 5/09/16 at 10:53 a.m. and accompanied by LPN #17 and CNA #34, indicated the following: an open wound to the resident's inner right buttock, approximately the the length of a small paper clip and the width of a pencil. The wound bed was dark pink and the surrounding skin was intact. Review of Resident #17's clinical record began on 5/4/16 at 3:06 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart failure, kidney failure, and type 2 diabetes. Resident #17 had a current physician's order for Duoderm (a hydrocolloid	F 0279	**F279 What corrective action will be accomplishedfor those resident found to have been affected by the deficient practice?** Review of Resident #17 care-plan and skin assessments completed May 20, 2016. Review shows that Treatment was effective as evidenced by area being resolved on May 16, 2016. Progression of this healing was consistent with an abrasion as well as past noted areas to her buttocks from her scratching buttocks. Review of records also indicates that care-plan was initiated on May 3 with revisions done on May 9 as well as May 16. **How other resident having the POTENTIAL to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All Residents have the potential to be affected. Care-Plans for all Residents being monitored for wound or non-wound areas were reviewed.This review was completed by May 27, 2016. No issues were identified. **What MEASURES will be put into**	06/11/2016

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	wound dressing) to be applied to an abrasion on her right buttock every three days and as needed for soilage. Resident #17 had a 3/6/16 quarterly Minimum Data Set (MDS) assessment, which indicated she was rarely/never understood and rarely/never made decisions. The assessment also indicated the resident required extensive assistance of two staff for bed mobility and was totally dependant for transfers. It also indicated she was totally incontinent of both bowel and bladder. Review of a New Skin Alteration Assessment, dated 5/2/16, indicated the following: "...area to right buttock measuring 0.7 cm in length and 2.8 cm in width, area is red in middle and appears to be sheered [sic]...." There was no care plan in place for the open wound to Resident #17's buttock until 5/9/16. Review of the clinical record indicated a care plan for an abrasion to the resident's right buttock was created on 5/9/16 for an effective date of 5/3/16 by the ADON. During an interview, on 5/11/16 at 1:58 p.m., the ADON indicated the careplan for the actual wound had not been implemented until 5/9/16.		**place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur?** InService with all Nurses was done May 20, 2016. Included in this InService was education for Nurses to continue to add all skin changes in care-plan.. **How the corrective actions will be MONITORED to ensure the deficient practice will not recur (what QualityAssurance program will be put into place and how often checked)** Care-plan will be monitored, using the Quality Assessment/Improvement Program Tool:(Attachment C) CarePlan Review. These audits will be done weekly X4 weeks and then monthly X3, then quarterly thereafter. Will follow through the monthly Quality Improvement meeting. **By what date the systemic changes will be completed** Date of compliance June 11, 2016 The facility respectfully requests a paper IDR for thiscited deficiency. We request this deficiency be eliminated from the annualsurvey. The facility will provide evidence that the care plan for resident #17was initiated timely after the resident acquired an abrasion to the leftbuttock. Resident #17 had a “New Skin Alteration Assessment”completed on 5-2-16 when the abrasion to the left buttock was noted. The woundnurse reviewed the area on 5-3-16. The physician was	

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	3.1-35(a)		notified and treatment wasordered. The care plan was originated on 5-3-16. Per the survey report the surveyor stated "the care plan wasnot initiated until 5-9-16". This is incorrect. As noted on the printed careplan, the origination date was 5-3-16. Any time the care plan is revised, therevision date changes. We believe this is the date the surveyor observed ratherthan the origination date. With this evidence provided, we request this citation bedeleted from the annual survey.	
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure a resident received oxygen per physician's orders and a urinary catheter was maintained safely for 1 of 1 residents reviewed for respiratory services and urinary catheter use (Resident #1). Findings include: On 5/9/16 at 2:47 p.m., Resident #1 was in bed with the head of the bed flat. Resident #1 was wearing oxygen tubing that was disconnected from the oxygen concentrator at his bedside. Resident #1	F 0282	**What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Resident was monitored for any changes in his breathing. His urine was also monitored for signs and symptoms of any adverse outcome. He has the order that oxygen may be removed for shower and beauty shop as needed. He did not experience any adverse outcomes. **How other resident having the POTENTIAL tobe affected by the same deficient practice will be identified and what**	06/11/2016

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	also had a catheter drainage bag sitting in the bed and propped on the left side of his abdomen. The catheter bag was empty and there was cloudy yellow urine in the bend of the catheter in the tubing. On 5/9/16 at 2:49 p.m., RN #39 indicated Resident #1 had returned to the facility approximately 15 minutes prior. She indicated she had helped the ambulance service staff return Resident #1 to bed, but did not connect his oxygen or hang his drainage bag below him. She indicated she had told the CNAs to do this when she saw them in the hallway later, but they must not have. Review of Resident #1's clinical record began on 5/9/16 at 3:29 p.m. Resident #1's diagnoses included, but were not limited to, dementia with behavioral disturbance, encephalopathy, type 1 diabetes, cerebrovascular disease affecting the right dominant side, and shortness of breath. Resident #1 had current physician's orders for oxygen at 2 liters per minute per nasal cannula continuously and to ensure catheter bag was below waist. 3.1-35(g)(2)		**correctiveactions will be taken?** All Residents with urinary catheter or oxygen have the potential to be affected. An audit of all Residents with a urinary catheter or oxygen were reviewed May 20, 2016, no issues were identified during the review. Verifications noted that all Residentswith a urinary catheter have an order to keep drainage bag below level of waist. Verifications also noted that all Residents that have oxygen orders also have order that it may be removed for shower and beauty shop. **What MEASURES will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur?** InService with employees in the nursing department was completed on May 20, 2016. This InService included educating all staff that upon a Residents return from an appointment, LOA or other reason that they would be re-entering our facility, Nurse is to check on that Resident as soon as their return is known and ensure all medical equipmentand devices are in accordance with Physician orders. **How the corrective actions will be MONITORED to ensure the deficient practice will not recur (what QualityAssurance program will be put into place and how often checked)** Care-Plan audits were completed on all Residents with oxygen or	

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			urinary catheters on May 20, 2016. Audit tool Quality Assessment/ImprovementProgram Tool:(Attachment C) Care Plan Review will be completed weekly X4 weeks, then monthlyX3 months then quarterly thereafter. New admissions, or Residents that obtain new order for oxygen or urinary catheter use will be audited at time orders are received to ensure staff aware of physician orders and are following those orders. Will follow this through the monthly Quality Improvement meetings. **By what date the systemic changes will be completed.** Date of compliance June 11, 2016	
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			
	Based on observation, interview and record review, the facility failed to ensure a resident received the assistance she needed for personal hygiene care related to removal of facial hair and oral care for 1 of 35 residents observed for grooming needs (Resident #26). Findings include: 1. During an observation of Resident #26	F 0312	**What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Resident #26 has had her facial hair removed and staff has assisted her with maintaining removal of facial hair. Resident #26 has been assisted with oral hygiene every AM & PM. **How other resident having the POTENTIAL to be affected by the same deficient practice will be identified and what**	06/11/2016

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	on 5/4/16 at 2:35 P.M., she was sitting in a wheelchair in her room. She had white facial hair on her chin. During an observation of Resident #26 on 5/5/16 at 8:44 A.M., she was sitting in a wheelchair in her room. She had white facial hair on her chin. During an observation of Resident #26 on 5/9/16 at 11:33 A.M., she was sitting in a wheelchair in the main dining room. She had white facial hair on her chin. During an interview with Resident #26 on 5/11/16 at 9:14 A.M., she indicated that staff shaved her facial hair when she received a shower. She also indicated staff would shave her at other times if they noticed it. During an interview with the Director of Nursing (DON) on 5/12/16 at 1:34 P.M., she indicated that a female resident should have facial hair plucked or shaved, whichever she preferred, daily with morning care. Resident #26's clinical record was reviewed on 5/9/16 at 11:09 A.M. Resident #26's current diagnoses included, but were not limited to, macular degeneration, atherosclerotic heart disease, and hypertension		**corrective actions will be taken?** All Residents have the potential to be affected. Audit was completed on May 13, 2016 of all female Residents; assistance with hair removal was given if needed. All Residents will be reviewed for the amount of assistance they require with oral hygiene, these reviews will be completed by June 11, 2016. Any changes that are needed will be communicated to staff through care-plan and assignment sheets. **What MEASURES will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** InService with employees in the nursing department was completed on May 20, 2016. This InService included educating all staff that Residents are to be offered assistance with oral hygiene at least every AM & PM, unless physician order indicates otherwise. InService also included need to check females for need for assist with facial hair removal with morning care. **How the corrective actions will beMONITORED to ensure the deficient practice will not recur (what QualityAssurance program will be put into place and how often checked)** Audit tool Quality Assessment/Improvement Program: NursingServices Review (Attachment D). will be completed weekly X4 weeks then	

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	Resident #26 had a current, 4/1/16, quarterly, Minimum Data Set (MDS)assessment which indicated she was cognitively intact, used a wheelchair for mobility and needed extensive assistance with personal hygiene. Review of the "Bath List", dated 4/19/16, and provided by the Administrator in Training (AIT) on 5/12/16 at 12:45 P.M., indicated Resident #26 got a shower on Tuesdays and Fridays weekly on the evening shift. Review of the "Shower/bath report", dated 4/29/16 through 5/12/16, and provided by the AIT on 5/12/16 at 12:58 P.M., indicated Resident #26 received a shower on 4/29/16, 5/3/16, 5/6/16 and 5/10/16. 2. Resident #26, on 5/5/16 at 9:03 A.M., did not have any natural teeth and did not have dentures in place. During a room observation on 5/12/16 at 8:30 A.M., a white toothbrush and a tube of toothpaste were on a shelf above the sink in Resident #26's bathroom. There was no label on the toothbrush or on the tube of toothpaste. Resident #26's roommate indicated the toothbrush and toothpaste did not belong to her.		monthly thereafter. New admissions will be audited at time of admission and amount of assistance that Resident needs with oral hygiene and hair removal will be established and communicated to employees providing care through care-plan and assignment sheet. Will follow through the monthly Quality Improvement meeting. **By what date the systemic changes will be completed** Date of compliance June 11, 2016	

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	During an interview with Resident #26 on 5/5/16 at 9:03 A.M., she indicated she used to reside on a different hall and they would provide her a toothbrush and toothpaste in the mornings to brush her gums. She also indicated that since she moved, she had not received oral care. During an interview with CNA #17 on 5/12/16 at 8:31 A.M., she indicated third shift was supposed to provide oral care when they got up Resident #26 for the day. She also indicated that she assumed that third shift did it, but did not get a rundown of specific care when she came on first shift. Resident #26 had a 4/13/16 care plan need regarding assistance with Activities of Daily Living (ADLs). An intervention for this need was to provide oral care twice daily with staff assistance. Review of Resident #26's current, 5/12/16, "Order Summary Report", provided by the DON on 5/12/16 at 10:02 A.M., included: "...set up oral care for resident every am...." Review of a facility policy titled, "Morning Care", dated 3/13/12, and provided by the DON on 5/12/16 at 8:56 A.M., included the following:			

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	"...Purpose: To cleanse and refresh resident, while stimulating circulation and providing comfort and preparing resident for the day...Procedure: ...4. Provide oral care by providing mouth care with toothbrush and toothpaste or oral swab and mouthwash...7. Remind or assist...residents to shave..." 3.1-38(a)(3)(A) 3.1-38(a)(3)(C) 3.1-38(a)(3)(D)			
F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure prevention and treatment, including assessment and monitoring, was completed for pressure ulcers for 2 of 3 residents reviewed for pressure ulcers (Resident #17 and # 26). Findings include:	F 0314	**What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Both resident's care plans and skin alterations reviewed. Healing process was consistent with Resident #17 area being a scratch; and with Resident #26 area being an abrasion. Treatment course and	06/11/2016

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	1. An observation of wound care for Resident #17, beginning on 5/09/16 at 10:53 a.m. and accompanied by LPN #17 and CNA #34, indicated the following: an open wound to the resident's inner right buttock, approximately the the length of a small paper clip and the width of a pencil. The wound bed was dark pink and the surrounding skin was intact. Review of Resident #17's clinical record began on 5/4/16 at 3:06 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart failure, kidney failure, and type 2 diabetes. Resident #17 had a current physician's order for Duoderm (a hydrocolloid wound dressing) to be applied to an abrasion on her right buttock every three days and as needed for soilage. Resident #17 had a 3/6/16 quarterly Minimum Data Set (MDS) assessment, which indicated she was rarely/never understood and rarely/never made decisions. The assessment also indicated the resident required extensive assistance of two staff for bed mobility and was totally dependant for transfers. It also indicated she was totally incontinent of both bowel and bladder.		care plan were effective as evidence by both Resident #17 and #26 areas resolved. **How other resident having the POTENTIAL to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be effected. All residents currently being monitored for non wounds were reviewed on May 20,2016 to ensure accuracy for treatment as well as on care plan, no issues were identified. **What MEASURES will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** InService with all Nurses was done May 20, 2016. Included in this InService was use of terminology used to describe non-wounds. **How the corrective actions will be MONITORED to ensure the deficient practice will not recur** (what Quality Assurance program will be put into place and how often checked) Using the Quality Assessment/Improvement ProgramTool: Pressure Ulcer Risk and Treatment, audits will be done weekly X4 and monthly thereafter. Will follow through monthly Quality Improvement meeting. By what date the systemic changes will be completed. Date of compliance	

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	Review of a New Skin Alteration Assessment, dated 5/2/16, indicated the following: "...area to right buttock measuring 0.7 cm in length and 2.8 cm in width, area is red in middle and appears to be sheered...." Review of a Wound Note, dated 5/9/16, and signed by the ADON, indicated the following: "...abrased [sic] area to right buttocks, without s/s (signs or symptoms) of infection. Staff will continue treatment of duoderm to cover thigh and change every day and PRN (as needed) after washing with soap and water...." There were no measurements or description of the wound indicated in the note. Review of a Wound Note, dated on 5/9/16 as a late entry for 5/3/16, and signed by the ADON, indicated the following: "...Abrased [sic] area to right buttocks...." Resident #17 had a current care plan problem of potential for skin breakdown due to bowel and bladder incontinence and impaired mobility. There was no care plan in place for the open wound to Resident #17's buttock until 5/9/16. Review of the clinical record indicated a care plan for an		June 11, 2016 The facility respectfully requests a paper IDR for thiscited deficiency. We request this deficiency be eliminated from the annualsurvey. The facility will present evidence through documentation to show thatthe areas for residents #17 and #26 were accurately assessed and facilitypolicy for non-pressure wounds was followed. Resident #17 was noted with a new skin alteration on 5-2-16.The “New Skin Alteration Assessment” was completed on this date. The facilitywound nurse assessed the area 5-3-16 and the care plan was initiated for theabrasion to the left buttock. Resident has history of scratching at buttocks.This area was not located on a bony prominence and was classified as anabrasion. Treatment was ordered and area healed without complications 5-16-16. Resident #26 was noted with new skin alteration on 3-23-16on the upper right heel. Area was an abrasion related to the resident’s shoerubbing. Again, the facility wound nurse observed the area. This area was notlocated on a bony prominence and was classified as an abrasion. Treatment wasordered and area healed without complications 5-16-16.. Care plan and treatmentwas initiated. As stated in the facility P/P for non-pressure areas, a skinalteration was completed.	

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	abrasion to the resident's right buttock was created on 5/9/16 for an effective date of 5/3/16 by the ADON. During an interview, on 5/10/16 at 1:35 p.m., CNA #35 indicated Resident #17 was to be laid down after meals due to her tendency to "scoot" while up in her wheelchair. During an interview, on 5/11/16 at 1:58 p.m., the ADON indicated the difference between a pressure ulcer and an abrasion was a pressure ulcer occurred in areas such as heels, gluteals, and the back of the head. She indicated abrasions occurred on the tops of thighs, to forearms, and hands and legs. She further indicated outer buttocks generally broke down from pressure and inner buttocks broke down from moisture. She indicated Resident #17's wound had been possibly caused by friction or shearing, which she indicated does not contribute to pressure wounds. She also indicated the wound may have been caused by the facility's perineal spray. She indicated she did not feel Resident #17's wound was caused by pressure, but was probably more from "scooting" in her wheelchair. She then agreed that "scooting" can be a contributing factor to pressure. The ADON indicated, since she did not		Proper notification was done and treatment was put inplace. The area was monitored by the facility nurses for changes as per thepolicy. Definition as written in the book: “Skin and WoundManagement Course” by the Wound Care Education Institute. The proper definitionof an abrasion: caused by shearing of skin by rough surface, superficial, akaroad rash.	

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	feel the area to Resident #17's right buttock was a pressure wound, the staff nurses would assess the area for worsening or improvement, but this had not been done. She further indicated the careplan for actual wound had not been implemented until 5/9/16. During the exit conference, on 5/12/16 at 4:18 p.m., the DON indicated the wound to Resident#17's right buttock may have been caused by the resident scratching her buttock during peri care and indicated she had been told the resident scratched at her skin during the observation on 5/9/16. There was no observation of Resident #17 reaching for her perineal or buttock area during the wound care observation. 2. During an interview with LPN #7 on 5/9/216 at 10:39 A.M., she indicated an area on Resident #26's right heel was caused by her shoe. She also indicated staff tried to encourage Resident #26 to leave her right shoe off and they were trying to get a bigger pair. During an interview with the Assistant Director of Nursing (ADON) on 5/11/16 at 1:57 P.M., she indicated she was the wound nurse and assessed the area to Resident #26's right heel. She indicated that she believed the area was up too high on the heel to be considered a pressure			

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	area. She further indicated that she believed Resident #26's shoes fit properly but encouraged her to not put a shoe on because it could irritate the area. Furthermore, she indicated the area was caused by Resident #26 removing her right shoe with her left foot and it caused an abrasion. During an interview with Resident #26 on 5/12/16 at 9:10 A.M., she indicated the area to her right heel was caused by her shoe rubbing it. She also indicated that she noticed her right heel was sore and alerted staff. Resident #26's clinical record was reviewed on 5/9/16 at 11:09 A.M. Resident #26's current diagnoses included, but were not limited to, macular degeneration, atherosclerotic heart disease, and hypertension. Resident #26 had a current, 4/1/16, quarterly, Minimum Data Set (MDS)assessment which indicated she was cognitively intact, used a wheelchair for mobility and needed extensive assistance with dressing. Review of a document titled, "Nursing-New Skin Alteration Assessment (non-occurrence)", dated 3/23/16, and provided by the ADON on			

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	5/11/16 at 2:09 P.M., included: "...1. NEW WOUND... B. Description of New Skin Alterations... 1cm x 3cm open area to R [right] heel, unattached edges, no exudate noted at this time, slight redness to surrounding skin. Cleaned with soap and water then covered with duoderm...." Review of a "Wound Note", dated 3/28/16, and provided by the ADON on 5/11/16 at 2:09 P.M., included: "Scabbed area remains to back of upper ankle from swelling and shoe irritation. Resident to leave shoe off and wear socks only. Staff to encourage to elevate lower extremities as tolerated...." The note was signed by the ADON. Review of "Progress Notes", dated 2/24/16 through 5/11/16, and provided by the ADON on 5/11/16 at 2:09 A.M., indicated nursing staff monitored placement of a dressing or applied a skin protectant but no further measurements or assessments of the wound were done. Review of a policy, titled "Wound & Non-wound Assessment & Documentation", dated 4/13/16, and provided by the DON on 5/12/16 at 9:02 a.m., indicated the following: "...1. ...A. ...Each week or more often if needed, the wound assessment will be completed to include: location, stage, current status,			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	measurement, description, pain associated, PUSH score and current treatment...C. Definitions of wounds: ...II. Stage II pressure ulcer- Partial Thickness- Partial thickness skin loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough...Presents as a shiny or dry shallow ulcer without slough or bruising...2. STAGING OF WOUNDS The wound nurse will stage wounds based upon current standards of practice...B. Definition of non-wounds: ...V. Abrasion- Skin has been rubbed or abraded away by friction such as a skinned knee. Usually pain present...." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to ensure	F 0315	**What corrective action will be accomplished for those**	06/11/2016

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 505 N BRADNER AVE MARION, IN 46952	

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	a urinary catheter was maintained in a safe manner for 1 of 1 residents reviewed for urinary catheter use (Resident #1). Findings include: On 5/9/16 at 2:47 p.m., Resident #1 had a catheter drainage bag sitting in the bed and propped on the left side of his abdomen. The catheter bag was empty and there was cloudy yellow urine in the bend of the catheter in tubing. On 5/9/16 at 2:49 p.m., RN #39 indicated Resident #1 had returned to the facility approximately 15 minutes prior. She indicated she had helped the ambulance service staff return Resident #1 to bed, but did not hang his drainage bag below him. She indicated she had told the CNAs to do this when she saw them in the hallway later, but they must not have. Review of Resident #1's clinical record began on 5/9/16 at 3:29 p.m. Resident #1's diagnoses included, but were not limited to, dementia with behavioral disturbance, encephalopathy, type 1 diabetes, cerebrovascular disease affecting the right dominant side, and shortness of breath. Resident #1 had current physician's orders to ensure catheter bag was below		**resident found to have been affected by the deficient practice?** Resident #1 was monitored for signs and symptoms of infection and any urinary changes. He remained without any adverse outcomes. **How other resident having the POTENTIAL to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with a catheter have the potential to be affected. All residents with urinary catheters were reviewed, and all have orders consistent with keeping drainage bag below the waist. All residents were found to have drainage bag in proper place, no issues were identified. **What MEASURES will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** InService, with all nursing department employees, was done May 20, 2016. Included in this InService was education reminding staff of appropriate placement of urinary drainage bag. The CNA task lists were updated to reflect proper placement of drainage bags. **How the corrective actions will be MONITORED to ensure the deficient practice will not recur** (what Quality Assurance program will be put into place and how often checked) Monitoring of	

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	his waist. 3.1-41(a)(2)		Residents with urinary catheters was completed on all Residents with urinary catheters on May 20, 2016. Audit tool Quality Assessment/Improvement Program Tool: Urinary Catheter Review (attachment F). will be completed weekly X4 and monthly thereafter. Will monitor this through the monthly Quality Improvement meeting. **By what date the systemic changes will be completed.** Date of compliance June 11, 2016.	
F 0323 SS=D Bldg. 00	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 and interview, the facility failed to ensure disposable razors were properly stored on a secured dementia unit. The deficit practice had the potential to affect 2 of 5 residents reviewed for independent mobility. (Resident's #3 and #100) Findings include: During an observation on the secure dementia unit on 5/4/16 at 2:31 p.m., two uncovered and unpackaged disposable razors were observed in a pink emesis basis in Resident #3's bathroom. There	F 0323	**What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Nurse secured razors in a safe location and informed resident #3 what she was doing with her razors. Discussed with family the importance of bringing supplies to nurse instead of giving to resident, in order to ensure safety of all residents. No adverse outcome with resident #3 or Resident #100. **How other resident having the POTENTIAL to be affected by the same deficient practice will be identified and what corrective actions will be**	06/11/2016

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	was one blue and one silver disposable razor. During an observation of Resident #3's bathroom with LPN #5 on 5/4/16 at 2:37 p.m., she indicated the disposable razors were to be locked in the medication storage room. She further indicated she was unaware of the disposable razors in Resident #3's bathroom and that family must have brought them in for the resident to use. During an interview with the Director of Nursing on 5/9/16 at 10:59 a.m., she indicated razors were not to be kept in the resident's drawers or on top of the sink of the bathroom. The Director of Nursing further indicated razors were to be kept in the locked utility room until used by staff. She indicated the family of Resident #3 had brought in the disposable razors for the resident and the facility was unaware of their presence and would contact the family. A review of the most current Minimum Data Set for Resident #3 and Resident #100 on 5/12/16 at 3 p.m., indicated they were able to ambulate without staff assistance, but cognitively impaired. No further information was provided on exit.		**taken?** All residents have the potential of being affected. All resident rooms were audited on May 19, 2016. There were no adverse outcomes with any residents. Any findings were corrected immediately. **What MEASURES will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** InService with all Nursing Staff was done May 20, 2016. **How the corrective actions will be MONITORED to ensure the deficient practice will not recur** (what Quality Assurance program will be put into place and how often checked) Audits using the Quality Assessment/Improvement Program: Resident Environment/Infection Prevention Observations (Attachment G) will be completed weekly X 4 and then monthly thereafter. Will follow through the monthly Quality Improvement meeting. **By what date the systemic changes will be completed.** Date of compliance June 11, 2016.	

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	3.1-45(a)(2)			
F 0328 SS=D Bldg. 00	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview, and record review, the facility failed to ensure a resident received oxygen per physician's orders for 1 of 1 residents reviewed for respiratory services (Resident #1). Findings include: On 5/9/16 at 2:47 p.m., Resident #1 was in bed with the head of the bed flat. Resident #1 was wearing oxygen tubing that was disconnected from the oxygen concentrator at his bedside. On 5/9/16 at 2:49 p.m., RN #39 indicated Resident #1 had returned to the facility approximately 15 minutes prior. She indicated she had helped the ambulance service staff return Resident #1 to bed,	F 0328	**What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Resident #1 was monitored for adverse reaction without a negative outcome noted. Resident was monitored for any changes in his breathing. No adverse signs or symptoms noted. He has an order for oxygen to be removed for shower and beauty shop as needed. **How other resident having the POTENTIAL to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with oxygen have the potential to be effected. An audit of all residents with oxygen was completed May 20, 2016, no issues identified. Verifications that any resident	06/11/2016

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	but did not connect his oxygen She indicated she had told the CNAs to do this when she saw them in the hallway later, but they must not have. Review of Resident #1's clinical record began on 5/9/16 at 3:29 p.m. Resident #1's diagnoses included, but were not limited to, dementia with behavioral disturbance, encephalopathy, type 1 diabetes, cerebrovascular disease affecting the right dominant side, and shortness of breath. Resident #1 had current physician's orders for oxygen at 2 liters per minute per nasal cannula continuously. 3.1-47(a)(6)		with oxygen has order to remove for shower and beauty shop if clinically appropriate. **What MEASURES will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** InService with employees in the nursing department was completed on May 20, 2016. This inService included educating all staff that upon a resident's return from an appointment, LOA or other reason, that they would be re-entering our facility, Nurse is to check on that resident as soon as their return is known and ensure all medical equipment and devices are in accordance with Physician orders. **How the corrective actions will be MONITORED to ensure the deficient practice will not recur** (what Quality Assurance program will be put into place and how often checked) Monitoring of Residents to verify that medical devices are used in accordance with physician orders and care-plan. This monitoring will be documented through Quality Assessment/Improvement Program Tool: Care Plan Review. (Attachment C). This will be completed weekly X 4 weeks, then monthly X3 months, then quarterly thereafter. New admissions, or residents that obtain new order for oxygen use, will be audited at time orders are received to ensure staff aware of	

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			physician orders and are following those orders. Will follow through monthly Quality Improvement meeting. **By what date the systemic changes will be completed.** Date of compliance June 11, 2016.	
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food was stored and served in a sanitary manner. This practice had the potential to affect 40 of 40 residents dining in the main dining room and 14 residents receiving pureed diets of 94 residents residing in the facility. Findings include: During initial tour of the facility kitchen, beginning on 5/4/16 at 9:18 a.m., the following was observed: The Dietary Manager (DM) was walking past the door to the kitchen, passing the steam table. She was not wearing a hair net.	F 0371	It is the policy of Miller's Merry Manor to ensure food is stored, and served in a sanitary manner All food items that were not covered completely were disposed of immediately. Staff members were educated on the importance of dating and labeling of food, use of hair nets, closing of the totes with lids were addressed at the time of the survey. All residents had the potential to be affected by the alleged deficient practice. The Dietary manager or designee will conduct a weekly sanitation audit in the kitchen and satellite areas weekly 1 month then conducted twice a month for two months then monthly thereafter. The Dietary Manager or designee will use the tool "Dietary food safety Sanitation checklist" (Attachment H) as the audit tool. The Dietary manager	06/11/2016

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	In the walk-in freezer, 18 biscuits were on the shelf in a paper storage pan. The original cellophane was open, causing the biscuits to be uncovered. The DM indicated the biscuits should have been covered. Two columns of ice were standing on the back shelf under the freezer compressor with ice on the floor underneath. On the dry storage shelves, a plastic bin containing onions was observed. Seven of the onions had large, green sprouts and a strong odor. One onion had mold covering the roots and bottom of the onion and one onion had collapsed into itself. In the walk-in refrigerator, an open, unmarked bag containing approximately three cups of wilting lettuce was observed on the shelf. Under the prep table, a large, undated bag, labeled as 50 pounds of oats, containing approximately 5 pounds of oats, was wadded and crushed into an open plastic tote containing another 50 pound bag of oats. The lid to the tote was sitting between the bags. The DM indicated the oats should have been stored in a closed container and dated.		or designee will then correct any identified findings and place concerns on the Quality Improvement Summary Log" (Attachment B). The Dietary manager or designee will be responsible for completing the Kitchen Sanitation Checklist tool weekly for the first month, then completing the tool twice a month for two months, then monthly thereafter. The Dietary manager or designee will then correct any identified findings and place concerns on the Quality Improvement Summary Log. (Attachment B). Dietary staff were inserviced on May 20th 2016 during the all staff inservice regarding the plan of correction. Dietary staff will be re inserviced again by June 11th 2016. Systematic changes will be completed by June 11 2016	

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	The DM indicated she should have worn a hairnet, but she was in a hurry and was "just passing through" the kitchen. During a dining observation, on 5/9/16 at 11:35 a.m., Cook #39 was carrying a tray with eight pieces of uncovered fruit pie, with the tray propped on her chest. Cook #39 began coughing and turned her head to the right, directing her cough to to her right chest and shoulder area. She then placed the tray on the counter and covered the pieces of pie with plastic wrap. Cook #39 then entered the kitchen and returned to the dining room serving area with another tray of pie, which was covered upon leaving the kitchen. On 5/11/16 at 9:55 a.m., during an observation of pureed food preparation, Cook #41 indicated she was preparing 14 servings of chicken for the residents that required pureed diet. She then obtained a food processor container from the storage shelf and began to scoop the cooked chicken into it. The lid to the processor container had a smear of a wet, white substance on the lip of the lid. When asked about the white, frothy debris in the bottom of the container, Cook #41 indicated it should have been clean when it was stored. She obtained a second container from the storage shelf, which also had a wet, white substance on the			

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	bottom of the container and on the blades. On 5/11/16 at 11:00 a.m., the DM indicated the food processor should not have been put away without being clean. She indicated she thought the cook had probably just rinsed it out between breakfast and lunch and didn't think anyone had actually put it in the dishwasher. Review of a policy, titled "Food Protection and Storage", dated 10/6/15, and provided by the DM on 5/11/16 at 11:05 a.m., indicated the following: "...1...all foods shall be stored and protected under safe and sanitary conditions... ...2...1...7...Open boxes, containers of food are securely enclosed, labeled, and dated...." Review of a policy, titled "Personal Hygiene", dated 7/20/15, and provided by the DM on 5/11/16 at 11:05 a.m., indicated the following: "...3...Hair restraints that completely cover the hair are to be worn at all times in the department to prevent hair from falling onto food and kitchenware...."			

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	3.1-21(i)(2)			
F 0441 SS=F Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens			

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	Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure facility staff followed infection control practices regarding: hygienic handling of foley catheters for 5 of 5 residents with catheters (Residents # 25, 101, 94, 107 &1); during ice pass for the secured unit which had the potential to effect 25 of 25 residents on the secured unit; proper handling of linens on the North 2 Hall, which had the potential to effect 27 of 27 residents residing on the hall; and proper handwashing practices and glove use were utilized for perineal care for 1 of 2 observations of perineal care (Resident #26). Findings include: 1. On 5/6/16 at 1:32 p.m., Resident #25 was in bed. Her foley catheter bag was hanging from a floor stand with the tubing touching the floor. On 5/6/16 at 3:15 p.m., Resident #25 was observed in bed. Her foley catheter bag was hanging from a floor stand with the tubing touching the floor. On 5/10/16 at 10:09 a.m., Resident #25 was observed in bed. Her foley catheter bag was hanging from a floor stand with the tubing touching the floor.	F 0441	**What corrective action will be accomplished for those resident found to have been affected by the deficient practice?** Findings were corrected at the time of discovery. Regarding handling of foley catheters; Resident #25, Resident #101, Resident #94, Resident #107 and Resident #1 remained without adverse outcomes. Ice pass on secured unit; Finding was corrected at the time of discovery. There were no adverse outcomes. Linen handling on N2 unit; finding was corrected at the time of discovery. There were no adverse outcomes. Handwashing and glove use with perineal care;findings were corrected at the time of discovery. Resident #26 had no adverse outcome. **How other resident having the POTENTIAL to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected. No new onset of infections have been identified in any resident, no issues noted. **What MEASURES will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** InService with all employees in every department was completed	06/11/2016

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	On 5/6/16 at 1:58 p.m., Resident #101 was seated in her wheelchair in the main dining room. Her foley catheter bag was suspended under her wheelchair with the tubing touching the floor. On 5/6/16 at 3:21 p.m., Resident #101 was seated in her wheelchair in the main dining room. Her foley catheter bag was suspended under her wheelchair, the tubing remained touching the floor. On 5/9/16 at 8:50 a.m., Resident #101 was seated next to LPN # 35 in the main dining room. Her foley catheter bag was suspended under her wheelchair, the tubing again was touching the floor. At 8:52 a.m., Resident #101 was propelled to the North 1 unit TV lounge by LPN #35, while the catheter tubing was dragging on the ground. On 5/9/16 at 9:49 a.m., Resident #94 was seated in his recliner chair in his room. His foley catheter bag was hanging from a floor stand next to the chair and the tubing was touching the floor. On 5/11/16 at 8:05 a.m., Resident #94 was seated in his wheelchair at a table in the North 2 unit dining room. His foley catheter bag was suspended under his wheelchair with the tubing touching the floor. On 5/12/16 at 7:56 a.m., Resident #94 was seated in his wheelchair at a table in the North 2 unit dining room.		on May 20, 2016. This InService included hand hygiene, fresh water pass, linen handling, peri-care, glove use, catheter tubing and drainage bag placement. Peri Care, Hand Hygiene and glove use skill checks will be completed by June 11, 2016. **How the corrective actions will be MONITORED to ensure the deficient practice will not recur** (what Quality Assurance program will be put into place and how often checked) Quality/Improvement Program: Resident Environment/Infection Prevention Observations (Attachment G).will be completed weekly X4 then monthly thereafter. Will follow through monthly Quality Improvement meeting. **By what date the systemic changes will be completed** Date of compliance June 11, 2016.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	His foley catheter bag was suspended under his wheelchair with the tubing touching the floor. On 5/9/16 at 12:05 p.m., Resident #107 was seated in his wheelchair at a table in the main dining room. His foley catheter bag was suspended under his wheelchair with the tubing touching the floor. On 5/10/16 at 8:15 a.m., Resident #1 was seated in his wheelchair at a table in the main dining room. His foley catheter bag was suspended under his wheelchair with the tubing touching the floor. During an interview, on 5/10/16 at 1:50 p.m., LPN #35 indicated foley catheter tubing and drainage bags were to be kept off of the floor for infection control purposes. During an interview, on 5/11/16 at 9:32 a.m., the DON indicated foley catheter tubing and drainage bags should not be on the floor and staff was aware to keep them off of the floor. Review of a policy titled, "Foley Catheter Care & Maintenance", dated 8/30/07, and provided by the DON on 5/11/16 at 2:30 p.m., indicated the following: "...A. Purpose 1. To reduce the			

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	likelihood of infection and to maintain a closed drainage system... E. Placement of Catheter Tubing Procedure 1. When in bed or wheel chair...c. Ensure bag or tubing is not touching floor...." 2. During an observation of the secure dementia unit on 5/5/16 at 2:37 p.m., an uncovered ice scoop was observed laying directly on the second shelf of a three tier cart. The top shelf held the ice cooler. CNA #2 picked up the ice scoop and scooped ice into Resident #3's water pitcher. During an observation on 5/5/16 at 2:38 p.m., LPN #5 had observed the uncovered ice scoop laying directly on the second shelf of the ice cooler cart and indicated to CNA #2 that she needed a new ice scoop and that it had to be in a cup. During an observation on 5/5/16 at 2:43 p.m., LPN #3 was observed with an ice scoop covered in plastic wrap and in a coffee cup. During an interview with CNA #2 on 5/5/16 at 2:43 p.m., CNA #2 indicated there usually was a scoop holder that matched the scoop located with the ice cooler at the ice machine, but there was not one today. She further indicated she			

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	did not have any plastic bags on her to place the scoop in, so she placed the ice scoop on the second shelf located under the ice cooler. A review of a policy titled "Ice Water Pass Procedure" dated 01/01/2009, was provided by LPN #1 on 5/12/16 at 10:15 a.m. and indicated the following: "...1. PURPOSE... * To provide the resident with a fresh supply of drinking water. 2. EQUIPMENT ...B. Scoop with holder... 3. PROCEDURE ...B. ...Keep ice scoop covered. ...C. ...replace ice scoop in proper covered container, or cover it with a clean towel or plastic bag to prevent contamination. ...I. ...Replace the scoop in covered container, clean towel or plastic bag between rooms to prevent contamination. ...4. Key Infection Control Measures: ...D. Do not lay scoop in ice chest." No further information was provided by exit on 5/12/16.			

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	3. During an observation of perineal care for Resident #26 on 5/11/16 starting at 11:34 A.M., the following occurred: CNA #17 washed her hands and donned gloves. CNA #21 washed her hands, she did not don gloves. CNA #17 removed her gloves and placed in a plastic bag. CNA #17 then removed a pink basin from a plastic bag. CNA #17 washed her hands, filled the pink basin with water and placed the pink basin on a bedside table. CNA #21 removed some books from the bedside table. CNA #21 then moved a stand-up lift and placed a lift belt behind Resident #26's back, she was not wearing gloves. CNA #17 donned gloves and fastened the lift belt buckle around Resident #26's upper abdomen. CNA #17 then pushed the stand-up lift toward Resident #26. CNA #17 also picked up perineal care spray. CNA #21 then donned gloves, she did not perform hand hygiene. On 5/11/16 at 11:45 A.M., the Assistant Director of Nursing (ADON) brought in a clean incontinent brief. CNA #21 picked up the remote for the stand up lift with her gloved hand and pushed a button that raised Resident #26 to a standing position, she did not remove her gloves. CNA #17 grabbed the handle of the stand-up lift with her gloved hands and			

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	pulled it away from Resident #26's wheelchair. She then pulled Resident #26's pants down, undid the Velcro straps on the brief, removed the soiled brief and placed it in a plastic bag. She did not remove her gloves. CNA #17 then placed a washcloth in the water in the pink basin, wrung the excess water out and sprayed the wet cloth with perineal care spray. CNA #17 then wiped the front of Resident #26's perineal area from front to back and then placed the used washcloth in a plastic bag. CNA #21 placed a washcloth in the water in the pink basin, wrung the excess water out and sprayed the wet cloth with perineal care spray. CNA #21 then wiped Resident #26's anal area from front to back and then placed the used washcloth in a plastic bag. CNA #17 and CNA #21 both removed their gloves and washed their hands. During an interview with CNA #21 on 5/11/16 at 11:52 A.M., she indicated she should have washed hands before she donned and after she removed her gloves. During an interview with CNA #17 on 5/11/16 at 11:54 A.M., she indicated she should have washed her hands and changed gloves after she touched the stand-up lift and before she provided care.			

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	A review of a policy titled "Peri Care" dated 01/01/2009, was provided by the Director of Nursing on 5/12/16 at 9:02 a.m. and indicated the following: "...1. PURPOSE * To cleanse the perineum for prevention of infection, irritation and to contribute to the residents positive self-image. ...3. PROCEDURE A. Obtain necessary equipment and take to residents bedside. B. Explain procedure to resident and provide privacy. C. Wash hands. D. Position resident... E. Apply gloves. F. Remove disposable brief or pad. ...I. Place brief or pad in plastic bag. J. Remove soiled gloves and wash hands. K. Fill wash basin with warm water and wet clean cloth with warm water from sink. L. Apply clean gloves. M. Female: Using peri care product and wet wash cloth, wash labia first.			

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	Always wash from front to back. Be sure to spread the labia and cleanse thoroughly. Rinse and dry completely. Turn the resident to the side and cleanse anal area thoroughly. Rinse and dry completely. ...O. Place soiled wash cloth in bag. P. Remove gloves and wash hands. Q. Apply appropriate brief product and/or clothing. ...U. Wash hands...." A review of a policy titled "Use of Medical Gloves (application and removal)" dated 06/09/2010, was provided by LPN #1 on 5/12/16 at 9:55 a.m. and indicated the following: "...1. POLICY: * 2) to reduce the risk of the germ dissemination to the environment and the transmission from the HCW's [health care worker] to the patient and vice versa, as well as from one patient to another. Gloves are worn to provide a protective barrier and prevent gross contamination of the hands when touching blood, body fluids, specimen collection,			

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	secretions, excretions, mucus membranes and non-intact skin. ...2. RATIONALE: A. Medical gloves are worn to reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to residents during invasive or other resident care procedures where contact may involve touching a residents mucous membrane and non-intact skin, secretions, excretions, blood or body fluids. ...C. Gloves should not be used as a substitute for handwashing. ...D. Gloves should be used for hand contaminating activities, handling soiled linen, when touching blood, body fluids, secretions, excretions, mucous membranes and non intact skin. ...3. GUIDELINES: A. Hands should be washed initially prior to putting on the gloves. ...D. Gloves should be removed and hands washed with soap and water immediately after glove removal. ...F. Gloves should be removed and hands washed when the integrity of the			

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	glove is in doubt. ...H. Gloves may need to be changed during the care of a single patient...." 4. During a random observation on 5/4/16 at 12:02 P.M., Laundry Aide #22 picked up clothes on a hanger. The clothes brushed against her scrub top. Laundry Aide #22 then took the hanging clothes into Room 189. She exited room 189 with no clothes. During a random observation on 5/4/16 at 12:04 P.M., Laundry Aide #22 picked up clothes on a hanger. The clothes brushed against her scrub top. Laundry Aide #22 then took the hanging clothes into Room 190. She exited room 190 with no clothes. During an interview with Laundry Aide #22 on 5/4/16 at 12:04 P.M., she indicated she had been working in the laundry for a month and that was her typical way of transporting laundry. She also indicated she knew to keep laundry away from her clothing but sometimes it was hard to do. A review of a policy titled "Linen Handling" dated 06/09/2010, was provided by LPN #1 on 5/11/16 at 11:30 a.m. and indicated the following:			

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	"...1. POLICY: * Linens and laundry are handled or transported in a manner to prevent the spread of infection and/or contamination. 2. GUIDELINES: ...F. Linen should not be held against the staff member's uniform during transport or delivery...." 3.1-18(b)(1) 3.1-18(l) 3.1-19(g)			