

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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F000000	<p>This visit was for the Investigation of Complaint IN00143744 and IN00145184.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaints IN00142108 and IN00142323 completed on January 23, 2014.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00141207 completed on December 17, 2013.</p> <p>Complaint IN00143744-Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00145184-Substantiated. Federal/State deficiencies related to the allegations are cited at F-157, F-281, 282, & F-314.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: March 10, 11, & 12, 2014.</p> <p>Facility number: 000018</p>	F000000		

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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	<p>Provider number: 155053 AIM number: 100273930</p> <p>Survey Team: Angel Tomlinson, RN, TC Barbara Gray, RN Leslie Parrett, RN</p> <p>Census bed type: SNF: 5 SNF/NF: 54 Residential: 21 Total: 80</p> <p>Census Payor type: Medicare: 3 Medicaid: 55 Other: 22 Total: 80</p> <p>Sample: 6</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 19, 2014, by Janelyn Kulik, RN.</p>				

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician and the resident's Power of Attorney (POA) for systolic blood pressure readings below 90, for 1 of</p>	F000157	1) Resident #A's POA was notified of all blood pressure reading outside of parameters on 3.4.14. Resident #A received a new order on 3.11.14 for a change in her blood pressure	03/22/2014			

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	<p>3 residents reviewed for notification in a sample of 6 residents. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 3/11/14 at 9:00 A.M. The resident's diagnoses included but were not limited to, anoxic brain damage, quadriplegia, and seizure disorder.</p> <p>Resident #A's Annual Minimum Data Set (MDS) Assessment dated 2/12/14, indicated Resident #A had unclear speech. She was usually understood and she understood others. She received tracheostomy suctioning and care.</p> <p>Resident #A's March 2014 Recapitulation order, initiated 1/28/13, indicated the following: The physician would be notified of a systolic blood pressure (measures the pressure in the arteries when the heart beats) reading below 90 or above 160 or a diastolic blood pressure (measures the pressure in the arteries between heart beats) reading below 50 or above 90.</p> <p>A review of Resident #A's blood pressure readings indicated the</p>		<p>medication related to low blood pressure readings . 2) Other residents with parameters for blood pressure and physician notification have the potential to be affected by this deficient practice. 100% audit completed to asses for residents requiring Physician and Family notification of blood pressure readings outside set parameters. 3) All nursing re-educated 3.17.14 on Physician and Family Notification of Condition Change policy and procedure (Attachment # 5) and on the Care plan Development and Review Policy and Procedure (Attachment#8) to ensure physician notification of any blood pressure readings outside ordered parameters, to ensure responsible parties are notified of any change in condition and any new orders and to ensure the plan of care is followed. 4) Corrective action will be QA monitored using the Physician Notification audit tool (Attachment #6) to ensure any resident with blood pressure readings outside of the set parameters will have these results called to the Physician for any necessary changes, and responsible parties will be notified and plan of care followed.. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x 3 months. Then monthly thereafter until audit shows 100% compliance x 3 months. The</p>		

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	<p>following blood pressures: On 1/7/14 her blood pressure reading was 82/54. On 1/29/14 her blood pressure reading was 86/52. On 1/30/14 her blood pressure reading was 83/54. On 2/28/14 her blood pressure reading was 84/54. No documentation was available indicating the physician or POA had been notified of Resident #A's blood pressure readings on 1/7/14, 1/29/14, or 1/30/14.</p> <p>On 3/11/14 at 9:56 A.M., LPN #4 indicated the physician was not notified of Resident #A's blood pressure readings on 1/29/14, or 1/30/14. She indicated Resident #A's POA was notified of Resident #A's blood pressure readings the weekend following Resident A's 2/28/14, blood pressure reading. She indicated the physician was notified of Resident #A's 2/28/14, blood pressure reading by fax on 3/3/14 . LPN #4 indicated if Resident #A showed no signs or symptoms of distress or illness the facility would fax the blood pressure results. She indicated after 5:00 P.M., the fax would be sent the next morning and after 5:00 P.M., on Friday the fax would be sent the following Monday. LPN #4 indicated the POA would be notified of the</p>		<p>results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.</p>				

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	<p>blood pressure readings if Resident #A's blood pressures were continuously out of the ordered perimeters, there were signs and symptoms of distress, or there was an order change. She indicated if a resident occasionally had a blood pressure reading outside the ordered perimeters, the POA would not be notified. LPN #4 was unable to provide documentation the physician or POA had been notified of Resident #A's blood pressure readings for 1/7/14, 1/29/14, and 1/30/14.</p> <p>The physician was notified by fax on 3/3/14, the Power of Attorney was concerned Resident #A's propranolol (antianginal, antihypertensive, vascular headache suppressant medication) was causing Resident #A's low blood pressure readings. The fax indicated Resident #A had been prescribed propranolol to counteract side effects of amantadine (antiviral, antiparkinsonian medication), which was discontinued a year ago.</p> <p>A physician's order for Resident #A dated 3/4/14, indicated Resident #A's propranolol was discontinued.</p> <p>This Federal tag relates to</p>			

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F000281 SS=D	<p>Complaint IN00145184.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on interview and record review, the facility failed to direct staff properly, in that LPN #2 directed CNA #3 to practice outside of her scope, placing Medihoney Gel treatment on a residents pressure ulcer, for 1 of 2 residents reviewed for pressure ulcers in a sample of 6 residents. (Resident #A)(LPN #2 and CNA #3)</p> <p>Findings include:</p>	F000281	<p>1) No negative effects to res. # A. Area healed without complication. LPN #2 counseled on scope of practice (Attachment # 1) and Pressure Ulcer Treatment Policy and Procedure (Attachment # 2). CNA # 3 counseled on Scope of Practice (Attachment #1) and CNA job description (Attachment # 3).</p> <p>2) No other residents were affected by the deficient practice. 100% audit completed on residents with pressure ulcers to ensure pressure ulcer treatment was applied properly and by a</p>	03/22/2014	

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	<p>Resident #A's record was reviewed on 3/11/14 at 9:00 A.M. The resident's diagnoses included but were not limited to, anoxic brain damage and quadriplegia.</p> <p>Resident #A's Annual Minimum Data Set (MDS) Assessment dated 2/12/14, indicated Resident #A had unclear speech. She was usually understood and she understood others. She required extensive assistance of 2 persons for bed mobility. She required total assistance of 2 persons to transfer and she did not walk. She was totally dependent on 1 person for personal hygiene. She had (2) Stage 1 unhealed pressure ulcers.</p> <p>A physician's order on Resident #A's February 2014 treatment record, initiated 1/30/14, the resident was ordered Medihoney Gel 2 times a day to her Stage 1 pressure ulcer located on her left and right buttock, followed by a dry dressing.</p> <p>A Pressure Ulcer Assessment for Resident #A dated 2/24/14, indicated the following: Resident #A had a pressure ulcer on her coccyx, originally noted on her left and right buttocks that had combined into 1 wound. The pressure area</p>		<p>Licensed Nurse. One resident in house with pressure area at time of audit. Area is improving. 3) All nursing staff re-educated 3.17.14 on Pressure Ulcer Policy and Procedure (Attachment #2) and CNA scope of practice (Attachment #1). 4) Corrective action will be QA monitored using the Nursing Scope of Practice audit tool (Attachment #4) to ensure pressure ulcer treatments are applied only by a Licensed Nurse. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x 3 months. Then monthly thereafter until audit shows 100% compliance x 3 months. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.</p>	

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	<p>measured 2.2 centimeters (cm) in length, 2.0 cm wide, and less than 0.1 cm in depth.</p> <p>During a telephone interview with LPN #2 on 3/10/14 at 8:25 P.M., she indicated Resident #A's Medihoney Gel was kept in the treatment cart. She indicated one time she had requested CNA #3 place the Medihoney Gel treatment on Resident #A's coccyx/buttock area. She indicated she had not understood the indications for Medihoney Gel or she wouldn't have requested CNA #3 place the gel on the resident. She indicated she was now aware the CNA's were not to provide a resident with the Medihoney Gel treatment. She indicated the Medihoney Gel treatment order for Resident #A had not included a covering or dressing. She indicated Resident #A had not had an open area at that time.</p> <p>During a telephone interview with CNA #3 on 3/10/14 at 8:45 P.M., she indicated one time LPN # 2 had requested her to place Medihoney Gel on Resident #A's buttock. She indicated she felt like it was something the nurse was responsible for, but since the nurse had requested her to do it, she felt it</p>						

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	<p>must be alright. She indicated she now knew it was the nurses responsibility. She indicated CNA #5 was with her in Resident #A's room at that time and CNA #5 had removed the dressing and she herself had put the Medihoney Gel on with a gloved hand. She indicated a dressing was not placed over the gel.</p> <p>On 3/11/14 at 11:25 A.M., the Director of Nursing (DoN) indicated CNA #3 had placed the Medihoney Gel on Resident #A's buttock on 2/24/14. She indicated LPN #2 and CNA #3 had been educated regarding the incident. She indicated it was a nurses responsibility to put Medihoney Gel on a resident.</p> <p>The Honey Farm website indicated Medihoney was an antibacterial topical honey preparation which was to be used for both chronic and acute wound care. It has been clinically proven effective for, providing a moist wound healing environment, protecting the wound by creating a barrier against wound pathogens including antibiotic resistant strains, providing a cleaner wound, rapidly removing malodor, and reducing the risk of infection</p>						

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F000282 SS=D	<p>from bacteria.</p> <p>Pressure ulcer treatment was not indicated on the most recent "Role of the Nurse Aide" policy and procedure provided by the DoN on 3/11/14 at 11:28 A.M.</p> <p>This Federal tag relates to Complaint IN00145184.</p> <p>3.1-35(g)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review the facility failed to ensure care plans and physician orders were followed for 2 of 3 residents reviewed in a sample of 6 related to fall interventions being in place and following the physician order to notify the physician of blood pressures that were out of the parameters (Resident #F & Resident #A).</p>	F000282	<p>1) Resident #A's POA was notified of all blood pressure reading outside of parameters on 3.4.14. Resident #A received a new order on 3.11.14 for a change in her blood pressure medication related to low blood pressure readings .Resident #F was affected by the deficient practice. No injury occurred. CNA #1 counseled on following the CNA assignment sheet (Attachment # 7). Resident #F's room rearranged to prevent unwanted bed movement. 2)</p>	03/22/2014

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	<p>Findings include:</p> <p>1. During an interview on 3-10-14 at 1:52 p.m. Resident #F indicated the last fall she had she was transferring out of the bed to the wheelchair. The resident indicated had slid or the bed slid, she was unsure which one. An observation of the resident's bed at this time indicated there were no wood blocks under the resident's wheels of her bed.</p> <p>Review of the record for Resident #F on 3-10-14 at 3:06 p.m. indicated the resident's diagnoses included, but were not limited to, congestive heart failure, anxiety, malaise and fatigue, osteoporosis, depression, seizure disorder, unspecified debility and morbid obesity.</p> <p>The Quarterly Minimum Data (MDS) Assessment for Resident #F dated, 12-4-13 indicated the resident required extensive assistance of two people to transfer.</p> <p>The fall risk care plan for Resident #F dated, 2-21-14 indicated the resident had multiple risk for falls due to seizure disorder, weakness, history of a foot fracture, osteoporosis and a hearing deficit. The interventions included, but were</p>		<p>Other residents with parameters for blood pressure and physician notification have the potential to be affected by this deficient practice. 100% audit completed to asses for residents requiring Physician and Family notification of blood pressure readings outside set parameters. All residents have the potential to be affected by this deficient practice if the incorrect number of assistance is used with transfers, ambulation, and care. 100% audit completed to ensure the proper number of staff required for safe care is documented on the CNA assignment sheet (Attachment # 7) and resident plan of care. 100% audit of fall interventions completed to ensure all fall interventions are current and implemented. 3) All nursing re-educated 3.17.14 on Physician and Family Notification of Condition Change policy and procedure (Attachment # 5) and on the Care plan Development and Review Policy and Procedure (Attachment#8) to ensure physician notification of any blood pressure readings outside ordered parameters, to ensure responsible parties are notified of any change in condition and any new orders and to ensure the plan of care is followed. All nursing re-educated 3.17.14 on the use of CNA assignment sheets (Attachment # 7) and on the Care Plan Development and Review Policy and Procedure</p>		

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	<p>not limited to, the resident to be transferred with the assistance of two staff members at all times and will have bed chucked with wood blocks by maintenance.</p> <p>The occurrence initial assessment for Resident #F dated, 3-1-14 at 7:10 a.m. indicated the resident had a fall with no injury. The resident had to be lowered to the floor while getting the resident up.</p> <p>The post occurrence assessment for Resident #F dated, 3-3-14 indicated the resident was being transferred from her bed to the wheelchair with assistance of one person. The resident was lowered to the floor. The root cause of the fall was the resident was being transferred incorrectly.</p> <p>Interview with the Director Of Nursing on 3-11-14 at 11:45 a.m. indicated Resident #F fell on 3-1-14 because the resident was being transferred by CNA #1 and there should have been two staff transferring the resident. The DON indicated Resident #F told her the reason that she fell was because she just couldn't stand.</p> <p>Interview with CNA #1 on 3-11-14 at</p>		<p>(Attachment # 8) to ensure staff awareness of proper number of staff required to provide care, transfer, or walking assistance and to ensure awareness of fall interventions listed in the resident plan of care. 4)Corrective action will be QA monitored using the Physician Notification audit tool (Attachment #6) to ensure any resident with blood pressure readings outside of the set parameters will have these results called to the Physician for any necessary changes, and responsible parties will be notified and plan of care followed.. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x 3 months. Then monthly thereafter until audit shows 100% compliance x 3 months. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented. Corrective action will be QA monitored using the Care Plan/ Assignment Sheet audit tool (Attachment #9.) The QA tool Care Plan/ Assignment Sheet audit tool (Attachment #9) will be used to ensure staff are using the proper number of staff to provide care, transfer, or walking assistance and to ensure fall interventions are implemented. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x 3 months. Then monthly thereafter until</p>		

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
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	<p>12:03 p.m. indicated on 3-1-14 when Resident #F fell, the resident told her she could transfer her with one person. CNA #1 indicated she had a gait belt on the resident and went to stand the resident up from the bed to transfer her into the wheelchair and the bed was not locked and slid away from the resident. CNA #1 indicated she guided the resident to the floor with the gait belt.</p> <p>During an observation on 3-11-14 at 12:13 p.m. with the Maintenance Supervisor, Resident #F's bed did not have wood blocks under the resident's wheels of her bed. The Maintenance Supervisor indicated at this time he had not received a work order for the resident to have her bed chucked with wood blocks. The Maintenance Supervisor indicated he did not use wood blocks to chuck beds, that he used rubber stoppers and he would put some in place.</p> <p>2. Resident #A's record was reviewed on 3/11/14 at 9:00 A.M. The resident's diagnoses included but were not limited to, anoxic brain damage, quadriplegia, and seizure disorder.</p> <p>Resident #A's Annual Minimum Data Set (MDS) Assessment dated 2/12/14, indicated Resident #A had unclear</p>		audit shows 100% compliance x 3 months. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.				

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	<p>speech. She was usually understood and she understood others. She received tracheostomy suctioning and care.</p> <p>Resident #A's March 2014 Recapitulation order, initiated 1/28/13, indicated the following: The physician would be notified of a systolic blood pressure (measures the pressure in the arteries when the heart beats) reading below 90 or above 160 or a diastolic blood pressure (measures the pressure in the arteries between heart beats) reading below 50 or above 90.</p> <p>A review of Resident #A's blood pressure readings indicated the following blood pressures: On 1/7/14 her blood pressure reading was 82/54. On 1/29/14 her blood pressure reading was 86/52. On 1/30/14 her blood pressure reading was 83/54. On 2/28/14 her blood pressure reading was 84/54. No documentation was available indicating the physician had been notified of Resident #A's blood pressure readings on 1/7/14, 1/29/14, or 1/30/14.</p> <p>On 3/11/14 at 9:56 A.M., LPN #4 indicated the physician was not notified of Resident #A's blood pressure readings on 1/29/14, or 1/30/14. She indicated the physician was notified of Resident #A's blood pressure reading 2/28/14, on</p>			

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	<p>3/3/14. LPN #4 indicated if the Resident #A showed no signs or symptoms of distress or illness the facility would fax the blood pressure results. She indicated after 5:00 P.M., the fax would be sent the next morning and after 5:00 P.M., on Friday the fax would be sent the following Monday. LPN #4 was unable to provide documentation the physician was notified of Resident #A's blood pressure readings on 1/7/14, 1/29/14, and 1/30/14.</p> <p>This Federal tag relates to Complaint IN00145184.</p> <p>3.1-35(g)(2)</p>			

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to provide a qualified staff to provide a pressure ulcer treatment, which resulted in an unqualified staff providing a pressure ulcer treatment, for 1 of 2 residents reviewed for pressure ulcers in a sample of 6 residents. (Resident #A) (LPN #2 and CNA #3)</p> <p>Findings include:</p> <p>On 3/11/14 at 2:33 P.M., Resident #A was observed for perineal care (washing the genital, perineum, and anus area) by LPN #4 and RN #6. Resident #A had bright pink scar tissue on her coccyx going from the center out to both sides of her buttock.</p> <p>Resident #A's record was reviewed</p>	F000314	<p>1) No negative effects to res. # A. Area healed without complication. LPN #2 counseled on scope of practice (Attachment # 1) and Pressure Ulcer Treatment Policy and Procedure (Attachment # 2). CNA # 3 counseled on Scope of Practice (Attachment #1) and CNA job description (Attachment # 3).</p> <p>2) No other residents were affected by the deficient practice. 100% audit completed on residents with pressure ulcers to ensure pressure ulcer treatment was applied properly and by a Licensed Nurse. One resident in house with pressure area at time of audit. Area is improving. 3) All nursing staff re-educated 3.17.14 on Pressure Ulcer Policy and Procedure (Attachment #2) and CNA scope of practice (Attachment #1). 4) Corrective action will be QA monitored using the Nursing Scope of Practice audit tool (Attachment #4) to ensure pressure ulcer treatments</p>	03/22/2014			

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	<p>on 3/11/14 at 9:00 A.M. The resident's diagnoses included but were not limited to, anoxic brain damage and quadriplegia.</p> <p>Resident #A's Annual Minimum Data Set (MDS) Assessment dated 2/12/14, indicated Resident #A had unclear speech. She was usually understood and she understood others. She required extensive assistance of 2 persons for bed mobility. She required total assistance of 2 persons to transfer and she did not walk. She was totally dependent on 1 person for personal hygiene. She had (2) Stage 1 unhealed pressure ulcers.</p> <p>A physician's order on Resident #A's February 2014 treatment record, initiated 1/30/14, the resident was ordered Medihoney Gel 2 times a day to her Stage 1 pressure ulcer located on her left and right buttock, followed by a dry dressing.</p> <p>A Pressure Ulcer Assessment for Resident #A dated 2/24/14, indicated the following: Resident #A had a pressure ulcer on her coccyx, originally noted on her left and right buttocks that had combined into 1 wound. The pressure area measured 2.2 centimeters (cm) in</p>		are applied only by a Licensed Nurse. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x 3 months. Then monthly thereafter until audit shows 100% compliance x 3 months. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.				

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	<p>length, 2.0 cm wide, and less than 0.1 cm in depth.</p> <p>During a telephone interview with LPN #2 on 3/10/14 at 8:25 P.M., she indicated Resident #A's Medihoney Gel was kept in the treatment cart. She indicated one time she had requested CNA #3 place the Medihoney Gel treatment on Resident #A's coccyx/buttock area. She indicated she had not understood the indications for Medihoney Gel or she wouldn't have requested CNA #3 place the gel on the resident. She indicated she was now aware the CNA's were not to provide a resident with the Medihoney Gel treatment. She indicated the Medihoney Gel treatment order for Resident #A had not included a covering or dressing. She indicated Resident #A had not had an open area at that time.</p> <p>During a telephone interview with CNA #3 on 3/10/14 at 8:45 P.M., she indicated one time LPN # 2 had requested her to place Medihoney Gel on Resident #A's buttock. She indicated she felt like it was something the nurse was responsible for, but since the nurse had requested her to do it, she felt it must be alright. She indicated she</p>			

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	<p>now knew it was the nurses responsibility. She indicated CNA #5 was with her in Resident #A's room at that time and CNA #5 had removed the dressing and she herself had put the Medihoney Gel on with a gloved hand. She indicated a dressing was not placed over the gel.</p> <p>On 3/11/14 at 11:25 A.M., the Director of Nursing (DoN) indicated CNA #3 had placed the Medihoney Gel on Resident #A's buttock on 2/24/14. She indicated LPN #2 and CNA #3 had been educated regarding the incident. She indicated it was a nurses responsibility to put Medihoney Gel on a resident.</p> <p>The most recent Pressure Ulcer Treatment policy and procedure provided by the DoN on 3/11/14 at 11:28 A.M., indicated the following: "... Procedure: B. All pressure ulcers will be assessed and measured weekly according to each facilities schedule and designated wound nurse...."</p> <p>This Federal tag relates to Complaint IN00145184.</p> <p>3.1-40(a)(2)</p>						

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to transfer a resident with the assistance of two staff, failed to implement a fall intervention of wood blocks under a resident's bed and failed to have the bed locked during a transfer resulting in a resident falling for 1 of 3 residents sampled for falls in a total sample of 6 (Resident #F).</p> <p>Finding include:</p> <p>During an interview on 3-10-14 at 1:52 p.m. Resident #F indicated the last fall she had she was transferring out of the bed to the wheelchair and either she had slid or the bed slid. The resident indicated she was unsure which one. An observation of the resident's bed at this time indicated there were no wood blocks under the resident's wheels of her</p>	F000323	<p>1)Resident #F was affected by the deficient practice. No injury occurred. CNA #1 counseled on following the CNA assignment sheet (Attachment # 7). Resident #F's room rearranged to prevent unwanted bed movement. 2) All residents have the potential to be affected by this deficient practice if the incorrect number of assistance is used with transfers, ambulation, and care. 100% audit completed to ensure the proper number of staff required for safe care is documented on the CNA assignment sheet (Attachment # 7) and resident plan of care. 100% audit of fall interventions completed to ensure all fall interventions are current and implemented. 3) All nursing re-educated 3.17.14 on the use of CNA assignment sheets (Attachment # 7) and on the Care Plan Development and Review Policy and Procedure (Attachment # 8) to ensure staff awareness of proper number of staff required to provide care,</p>	03/22/2014			

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	<p>bed.</p> <p>Review of the record for Resident #F on 3-10-14 at 3:06 p.m. indicated the resident's diagnoses included, but were not limited to, congestive heart failure, anxiety, malaise and fatigue, osteoporosis, depression, seizure disorder, unspecified debility and morbid obesity.</p> <p>The Quarterly Minimum Data (MDS) Assessment for Resident #F dated, 12-4-13 indicated the resident required extensive assistance of two people to transfer.</p> <p>The fall risk care plan for Resident #F dated, 2-21-14 indicated the resident had multiple risk for falls due to seizure disorder, weakness, history of a foot fracture, osteoporosis and a hearing deficit. The interventions included, but were not limited to, the resident to be transferred with the assistance of two staff members at all times and will have bed chucked with wood blocks by maintenance.</p> <p>The occurrence initial assessment for Resident #F dated, 3-1-14 at 7:10 a.m. indicated the resident had a fall with no injury. The resident had to be lowered to the floor while</p>		<p>transfer, or walking assistance and to ensure awareness of fall interventions listed in the resident plan of care. . 4) Corrective action will be QA monitored using the Care Plan/ Assignment Sheet audit tool (Attachment #9.) The QA tool Care Plan/ Assignment Sheet audit tool (Attachment #9) will be used to ensure staff are using the proper number of staff to provide care, transfer, or walking assistance and to ensure fall interventions are implemented. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x 3 months. Then monthly thereafter until audit shows 100% compliance x 3 months. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.</p>		

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	<p>getting the resident up.</p> <p>The post occurrence assessment for Resident #F dated, 3-3-14 indicated the resident was being transferred from her bed to the wheelchair with assistance of one person. The resident was lowered to the floor. The root cause of the fall was the resident was being transferred incorrectly.</p> <p>The fall risk assessment for Resident #F dated, 3-3-14 indicated the resident had confusion/forgetfulness, weakness, uses assistive device for mobility, unsteady gait with or without assistive devices, had impaired balance with transfers with or without assistive devices, requires staff to physically support her while transferring.</p> <p>Interview with the Director Of Nursing on 3-11-14 at 11:45 a.m. indicated Resident #F fell on 3-1-14 because the resident was being transferred by CNA #1 and there should have been two staff transferring the resident. The DON indicated Resident #F told her the reason that she fell was because she just couldn't stand.</p>				

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	<p>Interview with CNA #1 on 3-11-14 at 12:03 p.m. indicated on 3-1-14 when Resident #F fell, the resident told her she could transfer with one person. CNA #1 indicated she had a gait belt on the resident and went to stand the resident up from the bed to transfer into the wheelchair and the bed was not locked and slid away from the resident. CNA #1 indicated she guided the resident to the floor with the gait belt.</p> <p>During an observation on 3-11-14 at 12:13 p.m. with the Maintenance Supervisor, Resident #F's bed did not have wood blocks under the resident's wheels of her bed. The Maintenance Supervisor indicated at this time he had not received a work order for the resident to have her bed chucked with wood blocks. The Maintenance Supervisor indicated he did not use wood blocks to chuck beds, that he used rubber stoppers and he would put some in place.</p> <p>Interview with the MDS Coordinator on 3-11-14 at 12:16 p.m. indicated it was the responsibility of the Unit Manager and DON to ensure fall interventions were in place.</p> <p>The fall management procedure provided by the DON on 3-11-14 at</p>						

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	<p>3:00 p.m. indicated "the purpose was to assess all residents for risk factors that may contribute to falling and to provide planned interventions identified by the team as appropriate for resident use in maintaining or returning to the highest level of physical, social, and psychosocial functioning as possible."</p> <p>3.1-45(a)(2)</p>			