

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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F0000	<p>This visit was for the Investigation of Complaint IN00103387.</p> <p>Complaint IN00103387-Substantiated. Federal/state deficiencies related to the allegation are cited at F282 and F323.</p> <p>Survey dates: February 7 & 8, 2012</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 61 Total: 70</p> <p>Census payor type: Medicare: 13 Medicaid: 52 Other: 5 Total: 70</p> <p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	Quality review completed on February 9, 2012 by Bev Faulkner, RN			
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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure Physician orders were followed related to not completing a transfer with the assistance of two staff member as ordered for 1 of 4 residents reviewed for following Physician orders in the sample of 4. (Resident #C) (CNA #1)</p> <p>Finding include:</p> <p>The record for Resident #C was reviewed on 2/7/12 at 10:55 a.m. The resident was admitted to the facility on 10/28/11. The resident's diagnoses included, but were not limited to, convulsions, congestive heart failure, high blood pressure, and transient cerebral ischemia.</p> <p>A Physician's order was written on 11/30/11 to discontinue the use of the Hoyer lift for transfers and staff were to start to stand, pivot, and transfer the resident to all surfaces with 2 assists and the use of a gait belt.</p> <p>An Initial Nursing Occurrence Note was made on 1/10/12 at 10:19 p.m. The note indicated the site and time of the occurrence was on 1/10/12 at 8:00 p.m.,</p>	F0282	<p>It is the policy of Miller's Merry Manor, Hobart to ensure services provided by or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care. Resident # C: Continues with therapy services and as of 1/10/2012 a hoyer lift for all transfers with two assist completed per nursing. C.N.A. #1 is no longer employed. All residents with a physician's order to transfer utilizing two staff were at risk to be affected by the deficient practice. Physician orders for residents were reviewed by the DON or other nurse manager by 2/13/2012. How each resident transfers and the amount of assist required for transfer shall be included in the written plan of care. All residents will be reviewed by the DON or other nurse manager to determine the required assistance needed for transfer. HCP will be updated to reflect the transfer ability of each resident and the amount of staff assistance required for transfer. An all nursing staff in-service was held on 2/13/12 to discuss the importance of following each residents individual plan of care. The C.N.A. assignment sheets shall serve as the communication device for nursing staff to know</p>	02/15/2012			

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	<p>in the shower room. The writer of the note indicated staff reported to the writer they were transferring the resident from a shower chair into a wheel chair and the resident slid to the floor. No injuries were observed and neuro checks (checks to evaluate for change in neurological function) were started.</p> <p>A Post Fall Investigation form indicated the fall occurred on 1/10/2012 on the 3:00 p.m.- 11:00 p.m. shift when the resident was in the shower room and was being transferred by a CNA. The form also indicated staff were not assisting the resident as per the plan of care as two staff members were to transfer the resident. The cause of the fall was determined to be failure of the staff to transfer the resident with two assists.</p> <p>When interviewed on 2/7/12 at 12:20 p.m., the Director of Nursing indicated there were two CNA's in the shower room with the resident on 1/10/12 and CNA #1 did transfer the resident without the assistance of the second CNA. The Director of Nursing indicated the resident was to be transferred with the assistance of two staff members and CNA #1 did not follow the physician orders regarding the resident's transfer status.</p> <p>This Federal tag relates to Complaint</p>		<p>what the transfer needs are for each resident and the minimum amount of assistance required to complete safe transfer. The therapy department and restorative nurse/C.N.A. will continue to review each residents transfer ability quarterly and with any significant change in status to ensure HCP interventions for transfer to ensure adequate support is provided to each resident with transfers. Any identified changes in plan of care or physicians order related to transfers shall be promptly updated on the C.N.A. assignment sheets to ensure continuity of care. The facility conducts a job specific orientation process to ensure all new nursing staff are checked off on the proper use of mechanical lifts, gaitbelts, and following each residents plan of care. The DON or designee will observe transfers to ensure proper transfer technique utilization and staff assistance is provided with each observation. The quality assurance tool "Transfer Review" (Attachment A) will be completed on 3 residents every shift daily for a week, weekly for six weeks, then monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected and logged on a facility tracking log. The tracking log will be discussed/reviewed during the monthly facility quality assurance meeting to ensure</p>				

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	IN00103387. 3.1-35(g)(2)		compliance.	
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F0323 SS=D	<p>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.</p> <p>Based on observation, record review, and interview, the facility failed to provide adequate supervision for 1 of 4 residents in the sample of 4 reviewed for falls related to not transferring a dependent resident with the assist of two staff members which resulted in the resident sliding to the floor. (Resident #C) (CNA #1)</p> <p>Findings include:</p> <p>On 2/7/12 at 10:40 a.m., CNA #3 and CNA #4 were observed transferring Resident #C from his bed into his wheelchair in his room. The two CNA's transferred the resident using a Hoyer lift (a mechanical lift with a sling used to transfer residents).</p> <p>The record for Resident #C was reviewed on 2/7/12 at 10:55 a.m. The resident was admitted to the facility on 10/28/11. The resident's diagnoses included, but were not limited to, convulsions, congestive heart failure, high blood pressure, and transient cerebral ischemia.</p> <p>A Physician's order was written on</p>	F0323	<p>It is the policy of Miller's Merry Manor, Hobart to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident # C: Continues with therapy services and as of 1/10/2012 a hoyer lift for all transfers with two assists completed per nursing. C.N.A. #1 is no longer employed. All residents with a physician's order to transfer utilizing two staff were at risk to be affected by the deficient practice. Physician orders for residents were reviewed by the DON or other nurse manager by 2/13/2012. How each resident transfers and the amount of assist required for transfer shall be included in the written plan of care. All residents will be reviewed by the DON or other nurse manager to determine the required assistance needed for transfer. HCP will be updated to reflect the transfer ability of each resident and the amount of staff assistance required for transfer. An all Nursing staff in-service was held on 2/13/12 to discuss the importance of following each residents individual plan of care. The C.N.A.assignment sheets</p>	02/15/2012			

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	<p>11/30/11 to discontinue the use of the Hoyer lift for transfers and staff were to start to stand, pivot, and transfer the resident to all surfaces with 2 assists and the use of a gait belt. A Physician's order was written on 1/10/12 to transfer the resident with a Hoyer lift and to discontinue the 2 person manual transfer.</p> <p>A Fall Risk Assessment was completed on 10/28/11. The assessment indicated the resident was at high risk for falls based on diagnoses of seizures and hemiplegia and the required use of assistive devices for mobility. There was a care plan indicating the resident was an identified fall risk based on risk factors including confusion, poor trunk control and, poor positioning. The care plan was last revised on 12/5/11.</p> <p>The 11/4/11 Minimum Data Set (MDS) admission assessment indicated the resident's cognitive skills for decision making were severely impaired as the resident never or rarely made decisions. The assessment indicated the resident was totally dependent on staff assist of two or more persons for transfers and bathing. The assessment also indicated the resident had impairments in range of motion on both his upper and lower extremities.</p>		<p>shall serve as the communication device for nursing staff to know what the transfer needs are for each resident and the minimum amount of assistance required to complete safe transfer. The therapy department and restorative nurse/C.N.A. will continue to review each residents transfer ability quarterly and with any significant change in status to ensure HCP interventions for transfer to ensure adequate support is provided to each resident with transfers. Any identified changes in plan of care or physicians orders related to transfers shall be promptly updated on the C.N.A. assignment sheets to ensure continuity of care. The facility conducts a job specific orientation process to ensure all new nursing staff are checked off on the proper use of mechanical lifts, gaitbelts, and following each residents plan of care. The DON or designee will observe transfers to ensure proper transfer technique utilization and staff assistance is provided with each observation. The quality assurance tool "Transfer Review" (Attachment A) will be completed on 3 residents every shift daily for 7 days, then weekly for six weeks, then monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected and logged on a facility tracking log. The tracking log will be discussed/reviewed</p>				

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	<p>An Initial Nursing Occurrence Note was made on 1/10/12 at 10:19 p.m. The note indicated the site and time of the occurrence was on 1/10/12 at 8:00 p.m., in the shower room. The writer of the note indicated staff reported to the writer they were transferring the resident from a shower chair into a wheel chair and the resident slid to the floor. No injuries were observed and neuro checks (checks to evaluate for change in neurological function) were started.</p> <p>A Post Fall Investigation form indicated the fall occurred on 1/10/2012 on the 3:00 p.m.- 11:00 p.m. shift when the resident was in the shower room and was being transferred by a CNA. The form also indicated the staff were not assisting the resident as per the plan of care as two staff members were to transfer the resident. The cause of the fall was determined to be failure of the staff to transfer the resident with two assists.</p> <p>When interviewed on 2/7/12 at 12:20 p.m., the Director of Nursing indicated there were two CNA's in the shower room with the resident on 1/10/12 and CNA #1 did transfer the resident without the assistance of the second CNA. The Director of Nursing indicated the resident was to be transferred with the assistance of two staff members and CNA #1 did not</p>		during the monthly facility quality assurance meeting to ensure compliance.				

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	<p>follow the resident's transfer status. The Director of Nursing indicated the CNA#1 was suspended and due to not following policy with the transfer the CNA was then terminated.</p> <p>This Federal tag relates to Complaint IN00103387.</p> <p>3.1-45(a)(2)</p>			
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