

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155173	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/29/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR - MARION	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N BRADNER AVE MARION, IN 46952
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: June 23, 24, 25, 26 and 29, 2015</p> <p>Facility number: 000089 Provider number: 155173 AIM number: 100287760</p> <p>Census bed type: SNF: 10 SNF/NF: 89 Residential: 7 Total: 106</p> <p>Census payor type: Medicare: 15 Medicaid: 77 Other: 14 Total: 106</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL			

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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Bldg. 00	<p>RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview, and record review, the facility failed to utilize physical restraints only for medical reasons for 1 of 1 residents reviewed for restraints (Resident #47).</p> <p>Findings include:</p> <p>On 6/24/15 at 1:12 p.m., Resident #47 was seated in her reclined wheelchair. A vest harness was secured across her chest and a lap belt was secured across her lap. The vest harness was pulled down around her right upper arm with the left side of the vest pulled toward her neck.</p> <p>On 6/25/15 at 9:56 a.m., Resident #47 was seated in her reclined wheelchair. A vest harness was secured across her chest and a lap belt was secured across her lap. The vest harness was pulled down around her right upper arm with the left side of the vest pulled toward her neck.</p> <p>On 6/25/15 at 12:57 p.m., Resident #47 was seated in her reclined wheelchair in the main dining room with staff assisting her to eat. A vest harness was secured across her chest and a lap belt was</p>	F 0221	<p>F 221 - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #47 was reviewed by Medical Director and by therapy department. The positioning straps are found to be a medical necessity for this Resident. Order was written to support the medical necessity of these, and care-plan updated. All staff will be in-serviced by July 29th 2015. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 100% audit completed to identify those Residents that require the use of a positioning device while up. This audit was completed July 1, 2015. Any changes that were necessary were made and care-plans were updated, this was all completed by July 9th. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Those with existing positioning devices will be reviewed through Miller's Merry Manor Quality Assessment / Improvement Program the Restraint Assessment quarterly</p>	07/29/2015

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	<p>secured across her lap. The vest harness was pulled down around her right upper arm with the left side of the vest pulled toward her neck.</p> <p>On 6/26/15 at 8:26 a.m., Resident #47 was seated in her reclined wheelchair. A vest harness was secured across her chest and a lap belt was secured across her lap.</p> <p>Resident #47 had a current, 5/3/15, annual, Minimum Data Set assessment (MDS), which indicated she was rarely or never understood by others, rarely or never made decisions, and was totally dependent on staff for transfers and locomotion.</p> <p>Resident #47's clinical record was reviewed on 6/25/15 at 10:54 a.m. Resident #47's diagnoses included, but were not limited to, Down's syndrome, cognitive deficits due to cerebrovascular disease, and hemiplegia. There were no physician's orders for the vest harness or the lap belt to Resident #47's wheelchair.</p> <p>During an interview with the DON on 6/25/15 at 1:53 p.m., she indicated there was no order for the vest harness, nor lap belt, to Resident #47's wheelchair. She indicated the facility had not thought to get an order, since the resident had brought the wheelchair from home with</p>		<p>(Exhibit A). Any new positioning devices that any Resident admits with or acquires while in facility will be assessed upon initiation of device for the medical necessity for continued use and monitored quarterly thereafter through QA. The Admission Audit tool (Exhibit B) will indicate if a Resident is admitted with any of these. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Those with existing positioning devices will be reviewed through QA process quarterly. Any new positioning devices that any Resident admits with or acquires while in facility will be assessed upon initiation of device for medical necessity and monitored quarterly thereafter through QA. - by what date the systemic changes will be completed. July 29, 2015 is date certain for all corrections.</p>	

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F 0241 SS=D Bldg. 00	<p>both the vest harness and lap belt attached.</p> <p>3.1-3(w)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to provide a means of communication for 1 of 1 residents reviewed with a language barrier (Resident #74). Findings include: On 6/24/15 at 3:10 p.m., LPN #6 indicated Resident #74 was not able to be interviewed because she did not speak English. During an interview with the Social Services Director (SSD), on 6/25/15 at 10:32 a.m., she indicated Resident #74 communicated by using gestures and nodding yes or no. She also indicated Resident #74 would tap her hand to get staff attention or would come and get someone to assist her.</p>	F 0241	<p>F Tag 241 Dignity</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Insure communication tool is updated and in-place. It is a picture set with words written with words written in both English and Spanish. All staff will be in-serviced by July 29th 2105 about proper communication with all residents both verbal and non verbal. Resident understands both languages but is now using more non verbal methods to communicate. Resident had the picture tool in her room, and staff has been educated on its location.</p>	07/29/2015

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	<p>On 6/25/15 at 2:08 p.m., Resident #74 was sitting in her wheelchair in the doorway to her room. Resident #74 was gesturing to Housekeeper #8 with her hands at her chest in circles.</p> <p>Housekeeper #8 was asking the resident what she needed and listing items. Resident #74 indicated yes when Housekeeper #8 asked if she needed a bath. Housekeeper #8 then indicated, "I wish I spoke Spanish ", while raising her hands in the air.</p> <p>Resident #74's clinical record was reviewed on 6/26/15 at 9:10 a.m.</p> <p>Resident #74's diagnoses included, but were not limited to, cerebral ischemias, hemiplegia affecting dominant side, and aphasia due to cerebrovascular disease.</p> <p>Resident #74 had a current careplan for problem of psychosocial well-being and communication. Interventions included, but were not limited to, using communication tools and gestures to help communicate instructions.</p> <p>During an interview, with CNA #7, on 6/26/15 at 1:25 p.m., she indicated she could not have a conversation with Resident #74 because she did not speak Spanish. CNA #7 indicated Resident #74 was able to order her meals by pointing</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</p> <p>An audit, using form QA Resident Dignity (Exhibit C) will be completed on all residents who display communication difficulties. Those residents identified will have care plans updated to address communication abilities.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Residents will continue to be assessed upon admission, quarterly, annually and with significant changes for communication needs in conjunction with the MDS. Those identified will have Communicate needs addressed by the interdisciplinary care plan team.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur</p> <p>A Quality Assurance tool, Resident Dignity (Exhibit C) will be completed monthly with a random sample of residents. Any identified issues will be corrected Immediately. Form</p>	

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F 0314 SS=D Bldg. 00	<p>to her menu card and most staff knew the Spanish word for bathroom.</p> <p>During an interview, with the Social Services Assistant on 6/29/15 at 1:39 p.m., she indicated Resident #74 did not have communication tools in her room.</p> <p>During an interview with LPN #6 on 6/29/15 at 10:45 a.m., she indicated Resident #74 did not have a communication tool in her room. LPN #6 indicated Resident #74 would hit things to gain staff attention. She also indicated the nursing staff only spoke some simple words in Spanish, such as bathroom.</p> <p>3.1-3(t)</p> <p>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</p>	F 0314	<p>will be completed monthly for three months then quarterly thereafter as deemed appropriate through the QAA committee.</p> <p>- by what date the systemic changes will be completed.</p> <p>July 29, 2015 is date certain for all corrections.</p> <p>F 314 - what corrective action(s) will be accomplished for</p>	07/29/2015	

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	<p>record review, the facility failed to prevent the development of a pressure ulcer for 1 of 3 residents (Resident #22) and failed to identify risks for development of a pressure ulcer for 1 of 3 residents (Resident #30) reviewed for pressure ulcers.</p> <p>Findings Include:</p> <p>1. Resident #30's clinical record was reviewed on 6/26/15 at 9:36 a.m. Resident #30's diagnoses included, but were not limited to, congestive heart failure, diabetes type II, altered mental status, and idiopathic peripheral neuropathy.</p> <p>Resident #30's admission assessment, dated 12/10/14, indicated a history of a "sore to right heel."</p> <p>Resident #30 had a current 12/28/14 care plan for problem of potential for skin breakdown, with interventions including, but not limited to, a pressure relieving cushion to bed and chair. There were no interventions to prevent breakdown of the feet.</p> <p>Resident #30's Minimum Data Set assessment (MDS), dated 1/4/15, indicated she required extensive assistance of 2 staff members for bed</p>		<p>those residents found to have been affected by the deficient practice; Resident #30 care-plan was reviewed and deemed to be current and appropriate. All staff will be in-serviced by July 29th. Resident #22 is no longer a resident of the facility - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 100% audit for any Resident having "at risk for skin breakdown", interventions were reviewed and updates made as warranted. This was completed June 30, 2015.</p> <p>- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Admission Audit tool (Exhibit B) to include: ensuring C/P that identifies a Residents risk for skin breakdown and that interventions are in place based off of those identified risks. This audit tool to be completed with all new admissions. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Miller's Merry Manor Quality Assessment / Improvement Program</p> <p>PRESSURE ULCER RISK AND TREATMENT QA (Exhibit D) will be completed monthly with all new admits and with any Resident identified has having a</p>	

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	<p>mobility.</p> <p>Review of the "New Skin Alteration Assessment", dated 1/28/15, indicated the presence of a new purple bruise/pressure area to Resident #30's left heel.</p> <p>Review of the "Pressure Ulcer Assessment with Braden", dated 2/2/15, indicated a suspected deep tissue injury to the left heel, measuring 4.2 cm long by 4.5 cm wide.</p> <p>A revision of Resident #30's care plan, dated 2/21/15, indicated an increased risk for friction, shearing, and irritation to feet.</p> <p>During an interview with the Director of Nursing (DON), on 6/26/15 at 3:37 p.m., she indicated the risks for shearing to Resident #30's heels were not identified until 2/21/15.</p> <p>2. During an observation on 6/25/2015 at 3:17 p.m., CNA #1 removed Resident #22's shoe and sock from the left foot. No dressing was on the left great toe, in the sock or the shoe. There was a small dry tan stain on the sock. A small open wound was observed on the top of the left great toe.</p> <p>During an interview on 6/25/2015 1:50 at p.m., LPN #2 indicated Resident # 22 had</p>		<p>significant change. _ - by what date the systemic changes will be completed. July 29, 2015 is date certain for all corrections.</p>				

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	<p>a pressure sore on the right outer ankle and the resident had no other pressure ulcers. She indicated the evening shift did wound care for this resident. She also indicated Resident #22's left great toe was not a pressure sore, but a "Hallux Vulgas" (bunion).</p> <p>During an interview on 6/25/2015 at 3:40 p.m., the DON indicated the current order for Resident #22's left great toe was to have a dressing on the toe and changed daily.</p> <p>During an interview on 6/29/2015 at 8:57 a.m., CNA #4 indicated she had never noticed the left great toe dressing missing for Resident #22. She indicated if a wound dressing had come off, it was reported to the nurse immediately. She also indicated the resident's showers were on Tuesdays and Thursdays in the afternoons.</p> <p>On 6/26/2015 at 3:36 p.m., the Wound Care Nurse (WCN), and LPN #2 were observed doing the dressing change for Resident # 22. The left great toe pressure ulcer had a scant amount of light tan drainage on the old dressing. The wound was cleaned with wound cleanser. The wound measurements were 0.9 cm length x 1.1 cm width x 0.1cm depth with 100% slough over the wound, per the WCN.</p>			

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	<p>Santyl was applied to the wound bed and covered with an oil emulsion dressing then wrapped with gauze as ordered. During the dressing change on 6/26/2015 at 4:17 p.m., the WCN indicated all wounds were measured weekly.</p> <p>During an interview on 6/25/2015 at 3:00 p.m., the Wound Care Nurse (WCN), and the Director of Nursing (DON) indicated the open area on Resident #22's left great toe was caused by an ill fitting shoe. The staff were to measure pressure and non pressure wounds weekly and they acknowledged there had been no wound measurements done for this resident's for the left great toe since 5/4/15.</p> <p>On 6/23/2015 at 3:23 p.m., Resident #22 was observed sitting in his wheel chair in the front lobby watching traffic, his feet were not elevated.</p> <p>On 6/24/2015 at 8:27 a.m., Resident #22 was observed sitting in his wheel chair coming back from the bathroom, his feet were not elevated.</p> <p>On 6/25/2015 at 10:32 a.m., Resident #22 was observed sitting in his wheel chair in the front lobby looking out of picture window and indicated he participated in the activity of pets on a leash, his feet were not elevated.</p>			

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	<p>On 6/25/2015 at 2:00 p.m., Resident #22 was observed sitting in his wheel chair in his room, his feet were not elevated.</p> <p>On 6/26/2015 at 3:15 p.m., Resident #22 was observed sitting in his wheel chair in the dining room, his feet were not elevated.</p> <p>The clinical record for resident #2 was reviewed on 6/26/2015 at 1:55 p.m. Diagnoses included, but were not limited to, hemiplegia, hemiparesis, vascular dementia, hypertension, edema, cancer of the prostate, cerebral vascular accident, depression, and peripheral vascular disease.</p> <p>A physician's order, dated 4/28/15, for wound care for the left great toe indicated "cleanse wound daily with wound cleanser, apply santyl and moist gauze, cover with foam, and secure with tape."</p> <p>The " Wound: Pressure ulcer assessment w/ Braden (wound nurse only) ", dated 4/28/15, indicated the great toe pressure ulcer was stage 3 and measured 1.0 cm length by 1.0 cm width by 0.1 cm depth and 80% slough covered. The area was scabbed and the scab had come off, revealing slough.</p>			

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	<p>The " Wound: Pressure ulcer assessment w/ Braden (wound nurse only) ", dated 5/4/15, indicated the great toe pressure ulcer was stage 3 and measured 1.0 cm length by 1.0 cm width by 0.1 cm depth and 80% slough covered.</p> <p>No further wound assessments for the great left toe were done by the staff after 5/4/15 through 6/25/15. The resident was sent out to a wound clinic every two weeks.</p> <p>A physician's order, dated 5/18/15, indicated to "cleanse the area to left great toe with wound cleanser apply santyl, cover with foam dressing bid (twice daily)."</p> <p>A physician's order, dated 6/19/15, indicated wound care to the left great toe was "cleanse wound with wound cleanser, apply santyl cover with foam or oil emulsion dressing and secure with tape or kerlix apply two layer compression socks."</p> <p>The minimum data set, dated 5/8/15, indicated the resident had severe cognitive impairment, extensive assistance of 2 persons for bed mobility, transfers and toilet use, incontinent of urine, pressure ulcer stage 2.</p>			

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	<p>The care plan for Resident #22 included, but was not limited to the following:</p> <p>Problem: Skin risk-potential for skin breakdown, hemiparesis, chronic heart disease, hx cva or TIA's, incontinence, hammer toe deformity bil (sic) feet (L foot hallux valgus), edema. Interventions included: "remind or assist to turn at least every 2 hrs, skin assessment at least weekly by nurse, encourage resident to elevate legs/feet."</p> <p>"Problem: Left Hallux Scab risk for complications initiated 3/31/15, revised 3/31/15 reviewed 6/16/15. The goal was for the area to "heal without complications. Interventions included: monitor for pain or discomfort, monitor for s/s infection and notify MD as needed, santyl and moist gauze to L great toe open area, cover with foam secure, with tape change daily," initiated 4/28/25, revised on 5/7/15, reviewed 6/16/15.</p> <p>The most recent policy titled "Skin Management Program" provided by the DoN on 6/29/15 at 9:00 AM included:</p> <p>"1. PURPOSE:</p> <p>A. It is our policy to assess for and reduce risk factors that may contribute to the development of pressure ulcers and other skin</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155173	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/29/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR - MARION	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N BRADNER AVE MARION, IN 46952
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	<p>alterations unless the individual ' s condition demonstrates that the development is clinically unavoidable.</p> <p>2. PROCEDURE:</p> <p>A. RISK ASSESSMENT</p> <p>I. A comprehensive head to toe skin assessment (inspection) will be completed by a licensed nurse upon admission/return, and at least weekly thereafter ...</p> <p>H ...DOCUMENTATION:</p> <p>1. Routine daily and/or weekly skin assessment (daily or weekly).</p> <p>II. The wound nurse will follow up weekly and prn for all pressure ulcers and document in the EMR on the "Wound-Pressure ulcer assessment with Braden". In addition, the wound nurse will follow up on all non-pressure wounds weekly and prn and document in the EMR on the " Wound-non pressure assessment " (sic)...</p> <p>The Subject: Wound and non-wound Assessment and Documentation</p> <p>1. WOUNDS</p> <p>AEach week or more often if needed, the wound assessment will be completed to include:</p>			

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R 0000 Bldg. 00	<p>location, stage, current status, measurement, description, pain associated, PUSH score and current treatment.</p> <p>B. Even if the wound is being treated by a therapist or outside wound specialist, the facility will monitor the wound using the " Wound mgt. form " to track progress/regress...."</p> <p>3.1-40(a)(1)</p> <p>This survey was for a State Residential Licensure Survey.</p> <p>Residential Census: 7 Sample: 6</p> <p>Miller's Merry Manor of Marion was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000		