

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155102	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2013
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 635 OAKHILL AVE PLYMOUTH, IN 46563
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F000000	<p>This visit was for the Recertification and State Licensure survey. This visit included the the Investigation of Complaint #IN00134769</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00135315.</p> <p>Complaint #IN00134769- Substantiated. Federal/state deficiencies related to the allegation are cited at F465 and F371.</p> <p>Survey dates: August 20 - 26, 2013</p> <p>Facility number: 000041 Provider number: 155102 AIM number: 100275400</p> <p>Survey team: Julie Wagoner, RN, TC Deb Kammeyer, RN Lora Swanson, RN Shauna Carlson, RN</p> <p>Census bed type: SNF: 08</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>SNF/NF: 72 Residential: 02 Total: 82</p> <p>Census payor type: Medicare: 10 Medicaid: 59 Other: 13 Total: 82</p> <p>This deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on September 5, 2013, by Brenda Meredith, R.N.</p>				

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interviews, the facility failed to develop plans and effectively manage behaviors for 2 of 5 residents reviewed for unnecessary medications. (Resident #102 and 113)</p> <p>Finding includes:</p> <p>1. Resident #102 was observed, on 08/22/13 at 1:28 P.M., ambulating into the day room on the secured dementia unit. Resident ambulated by herself with no walker, walked a little stiffly, sat down in a recliner, and shut her eyes.</p> <p>Resident #102 was observed on 08/23/13 at 9:20 A.M., seated in the lounge on the unit asleep. At 9:30 A.M., Resident woke up and stood up and walked down the hall. Resident was noted to be slightly unsteady as she walked and once in hall, did use the handrail. Resident indicated she needed to get some medication that she had ran out of and needed to reorder it. Two staff members kept</p>	F000250	F-Tag 250: Provision of Medically Related Social Services: It is the policy of Miller's Merry Manor, Plymouth to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. Resident # 102 and 113: The care plans and resident assessments for behavioral symptoms/patterns were revised and updated for these two residents. Resident specific behavior plans and interventions will be communicated to the nursing staff via the Electronic Medical Record/POC Documentation (EMR/POC). Documentation of behavior episodes and the effectiveness of individualized interventions will be documented in the electronic medical record. All residents whose medication regimen includes psychoactive/psychopharmacological medications to treat behavioral/mood symptoms are at risk to be affected by the deficient practice. The facility nurse managers and social service designees will complete a behavior plan audit on all residents who are prescribed	09/25/2013	

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	<p>trying to use reality orientation and Resident #102 became increasingly agitated indicating she did not believe she did not have to order her medication. Resident told one of the staff to "quit ordering me around." Staff did offer resident "yahtzee" to play with other residents. Resident finally agreed to wait for the "nurse" to talk to her about her medications. Resident agreed to sit in a chair and promptly fell back asleep. At 10:04 A.M., staff woke the resident up and walked her to the dining room table for a snack.</p> <p>The clinical record for Resident #102 was reviewed on 08/22/13 at 1:00 P.M. Resident #102 was admitted to the facility on 06/06/12, with diagnosis, including but not limited to Alzheimer's disease, dementia with behavioral disturbances, psychosis, osteoporosis, osteoarthritis, episodic mood disorder, depressive disorder, diabetes, chronic airway obstructive disease, hypertension, anxiety disorder, insomnia, anorexia, panic disorder without agoraphobia, aphasia.</p> <p>Her admission physician orders for medications, on 06/06/12, included orders for the antipsychotic medication, Geodon 20 mg</p>		<p>psychopharmacological/psychoactive medications by 9/25/13. Each resident's medication regimen will be reviewed to ensure proper diagnosis/indication for ongoing use of psychopharmacological/psychoactive medications. Residents who display behavioral symptoms/mood issues will have their plan of care reviewed and will have resident specific interventions that assist to reduce/prevent the occurrence identified. An all nursing staff in-service will be held on or before 9/20/13 to review the facility policies for "Behavior Management Assessment /Program" and "Psychotropic Drug Use". The in-service will include assessment of behavior symptoms, including the definition, process for documenting new/ongoing behavioral symptoms, resident specific interventions, and documenting in the EMR. Emphasis on monitoring and care planning will be reviewed. The facility behavioral committee will meet monthly to monitor the effectiveness of interventions and the need to change/modify behavior programs to ensure psychosocial needs are met for each resident on an ongoing basis. The behavior tracking sheets, side effect monitoring sheets, interviews with staff/resident will be utilized to</p>		

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	<p>(milligrams) to be given three times a day for panic disorder/psychosis.</p> <p>The Geodon dose was reduced to 20 mg twice a day on 11/14/12. The Geodon dose was further reduced to 20 mg once a day on 02/28/13.</p> <p>However, a physician's order, dated 05/08/13, increased the Geodon from 20 mg once a day back to 20 mg twice a day at 2 P.M. and 8 P.M. for dementia with delusions and psychosis.</p> <p>The behavior tracking for Resident #102 was for "restlessness." There was no tracking for panic disorder, psychosis, or delusions. An interview with RN #8, the unit manager for the dementia unit, on 08/22/13 at 2:30 P.M., confirmed there was no place in the electronic system for the CNA's (certified nursing assistants) to document the resident's panic disorder, psychosis, or delusional behaviors.</p> <p>The current health care plans for Resident #102, current through 10/28/13, indicated a behavior care plan to address the resident's "restlessness." There was no plan to address the resident's panic disorder or delusional disorder.</p>		<p>evaluate resident specific behavioral plans during the monthly review. Changes in behavior care plans and interventions will be communicated to the nursing staff per the EMR/POC documentation. Charge nurses will be instructed to document any significant change in status such as: new onset of behavior/or worsening behaviors on the "Pertinent Charting Sheets". This report is routinely reviewed by the nurse managers to ensure significant changes in condition are readily addressed by members of the HCP team and to prevent use of unnecessary medications. The social service designee will be responsible to complete the QA tool titled "Behavior and Antipsychotic Medication Review" (Attachment #1) on 25% of the residents weekly x 4 weeks, then 25% of the residents quarterly thereafter to monitor for compliance. Any issues identified will be addressed immediately. Issues will be logged on the "QA Problem Summary Log" (Attachment 2). The log will be reviewed in the monthly QA meeting. Date of Compliance 9/25/13</p>				

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	<p>2. The clinical record for Resident #113 was reviewed on 08/22/13 at 1:15 P.M. Resident #113 was admitted to the facility on 01/01/13, with diagnoses, including but not limited to, senile dementia, diabetes, anxiety disorder, dementia with behavioral disturbances, hyperlipidemia, emphysema, chronic airway obstruction, and hypertension.</p> <p>The current medication orders for Resident #113 included the antianxiety medication, Lorazepam .5 mg to be given twice a day for anxiety.</p> <p>On 07/09/13, the physician discontinued the routine Lorazepam. However, on 07/17/13, nursing notes documented Resident #113 as having an excessive laughing episode which prevented the resident from completing her ADL's (activities of daily living) and indicated she became agitated with verbal cues. A physician's order was received on 07/17/13, for a one time order of Lorazepam. On 07/18/13, a physician's order was received to restart the resident's routine Ativan. An interview with RN #11, the dementia unit manager, on 08/22/13 at 10:00 A.M., indicated Resident</p>						

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	<p>#113 did show a change in behavior when her Ativan was discontinued but there was no documentation of the behavior, except in the one time charting of excessive laughing and the daily documentation regarding her physical behaviors of hitting, kicking, and pinching staff during care. There were no documented episodes of the physical behaviors from 07/09/13 - 07/16/13. There was one episode, on 07/17/13, on the night shift. There was no explanation given by RN #11 as to how Resident #113 displayed her anxiety and what interventions the facility utilized to respond to her anxiety. An interview with RN #8, the dementia unit manager, on 8/22/13 at 2:30 P.M., confirmed there was only one behavior of excessive laughing documented.</p> <p>The current health care plans for Resident #113, current through 10/06/13, indicated there was no specific plan to address the resident's anxiety. There was a plan to address the resident's behaviors of hitting, kicking, and pinching staff during care, for which she received an antipsychotic medication. However, there was no plan to address the resident's anxiety issues.</p> <p>3.1-34(a)(1)</p>				

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F000279 SS=D	<p>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.</p> <p>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.</p> <p>The care plan must describe the services 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).</p> <p>Based on observation, record review and interviews, the facility failed to develop a comprehensive care plan regarding behavior needs for 2 of 5 residents reviewed for unnecessary medications. (Resident #102 and #113)</p> <p>Finding includes:</p> <p>1. Resident #102 was observed, on 08/22/13 at 1:28 P.M., ambulating into the day room on the secured dementia unit. Resident ambulated by herself with no walker, walked a</p>	F000279	F-Tag 279 Comprehensive Care Plans It is the policy of Miller's Merry Manor, Plymouth to use the results of the comprehensive assessment to develop, review, and revise the resident's comprehensive plan of care. The health care plans for resident # 102 and 113 have been reviewed and updated. All residents are at risk to be affected by the deficient practice. The facility will continue to develop a comprehensive plan of care for each resident that includes objectives and timetables to meet the resident's medical, mental, psychosocial,	09/25/2013			

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	<p>little stiffly, sat down in a recliner, and shut her eyes.</p> <p>Resident #102 was observed on 08/23/13 at 9:20 A.M., seated in the lounge on the unit asleep. At 9:30 A.M., Resident woke up and stood up and walked down the hall. Resident was noted to be slightly unsteady as she walked and once in hall, did use the handrail. Resident indicated she needed to get some medication that she had ran out of and needed to reorder it. Two staff members kept trying to use reality orientation and Resident #102 became increasingly agitated indicating she did not believe she did not have to order her medication. Resident told one of the staff to "quit ordering me around." Staff did offer resident "yahtzee" to play with other residents. Resident finally agreed to wait for the "nurse" to talk to her about her medications. Resident agreed to sit in a chair and promptly fell back asleep. At 10:04 A.M., staff woke the resident up and walked her to the dining room table for a snack.</p> <p>The clinical record for Resident #102 was reviewed on 08/22/13 at 1:00 P.M. Resident #102 was admitted to the facility on 06/06/12, with diagnosis, including but not limited to</p>		<p>and nursing needs as identified by the comprehensive assessment. The last completed comprehensive assessment on each resident will be reviewed and utilized to ensure the plan of care is reflective of the residents needs as identified by the comprehensive assessment by 9/25/13. The MDS coordinator will be responsible to complete the quality assurance tool "RAI process/MDS review" (Attachment #3) weekly x4 on 25% of the residents then quarterly thereafter to ensure continued compliance. Any issues noted will be addressed. All issues /concerns will be logged on the QA Summary log. This will be reviewed in the monthly QA meeting. Date of Compliance: 9/25/13</p>		

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	<p>Alzheimer's disease, dementia with behavioral disturbances, psychosis, osteoporosis, osteoarthritis, episodic mood disorder, depressive disorder, diabetes, chronic airway obstructive disease, hypertension, anxiety disorder, insomnia, anorexia, panic disorder without agoraphobia, aphasia.</p> <p>Her admission physician orders for medications, on 06/06/12, included orders for the antipsychotic medication, Geodon 20 mg (milligrams) to be given three times a day for panic disorder/psychosis.</p> <p>The Geodon dose was reduced to 20 mg twice a day on 11/14/12. The Geodon dose was further reduced to 20 mg once a day on 02/28/13.</p> <p>However, a physician's order, dated 05/08/13, increased the Geodon from 20 mg once a day back to 20 mg twice a day at 2 P.M. and 8 P.M. for dementia with delusions and psychosis.</p> <p>The behavior tracking for Resident #102 was for "restlessness." There was no tracking for panic disorder, psychosis, or delusions. AN interview with RN #11, on 08/22/13 at 2:30 P.M. confirmed "restlessness" was</p>				

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	<p>the only behavior being tracked and monitored.</p> <p>The current health care plans for Resident #102, current through 10/28/13, indicated a behavior care plan to address the resident's "restlessness." There was no plan to address the resident's panic disorder or delusional disorder.</p> <p>2. The clinical record for Resident #113 was reviewed on 08/22/13 at 1:15 P.M. Resident #113 was admitted to the facility on 01/01/13, with diagnoses, including but not limited to, senile dementia, diabetes, anxiety disorder, dementia with behavioral disturbances, hyperlipidemia, emphysema, chronic airway obstruction, and hypertension.</p> <p>The current medication orders for Resident #113 included the antianxiety medication, Lorazepam .5 mg to be given twice a day for anxiety.</p> <p>On 07/09/13, the physician discontinued the routine Lorazepam. However, on 07/17/13, nursing notes documented Resident #113 as having an excessive laughing episode which prevented the resident from completing her ADL's (activities of</p>				

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	<p>daily living) and indicated she became agitated with verbal cues. A physician's order was received on 07/17/13, for a one time order of Lorazepam. On 07/18/13, a physician's order was received to restart the resident's routine Ativan. An interview with RN #11, the dementia unit manager, on 08/22/13 at 10:00 A.M., indicated Resident #113 did show a change in behavior when her Ativan was discontinued but there was no documentation of the behavior, except in the one time charting of excessive laughing and the daily documentation regarding her physical behaviors of hitting, kicking, and pinching staff during care. There were no documented episodes of the physical behaviors from 07/09/13 - 07/16/13. There was one episode, on 07/17/13, on the night shift. There was no explanation given by RN #11 as to how Resident #113 displayed her anxiety and what interventions the facility utilized to respond to her anxiety.</p> <p>The current health care plans for Resident #113, current through 10/06/13, indicated there was no specific plan to address the resident's anxiety. There was a plan to address the resident's behaviors of hitting, kicking, and pinching staff during</p>						

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	<p>care, for which she received an antipsychotic medication. However, there was no plan to address the resident's anxiety issues.</p> <p>3.1-35(a)</p>			

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F000314 SS=G	<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, record review and interview, the facility failed to implement specific interventions to prevent heel pressure ulcers for 1 resident in a sample of 4 residents reviewed for pressure ulcer development . (Resident #C)</p> <p>Finding includes:</p> <p>The clinical record for Resident #C was reviewed on 08/26/13 at 1:00 P.M. Resident #C was admitted to facility on 05/16/13, with diagnoses, including but limited to: paralysis agitans, diabetes, malaise and fatigue, anorexia, abdominal aneurysm non-ruptured, hypertension, hyperlipidemia, chronic kidney disease and acute conjunctivitis.</p> <p>The nursing admission assessment,</p>	F000314	<p>Miller's Merry Manor of Plymouth respectfully requests to IDR F314 SS G with a face to face conference. We do feel that the facility properly assessed the resident upon admission and developed an appropriate care plan for teh prevention of skin breakdown based upon the assessment findings adn risks. The facility initiated the "Risk for Skin Breakdown" care plan with interventions based upon the clinical assessments adn teh residents conditon at admission. F314 Treatment/Services to Prevent/Heal Pressure Sores: It is the policy of Miller's Merry Manor, Plymouth 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</p>	09/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155102	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/26/2013
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 635 OAKHILL AVE PLYMOUTH, IN 46563		
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	<p>completed on 05/16/13, indicated there were no pressure ulcers noted on Resident #C.</p> <p>The initial MDS (Minimum Data Set) assessment, completed on 05/24/13, indicated the resident had no pressure ulcer but was at risk for pressure ulcer development.</p> <p>The health care plan for Skin Risk, initiated on 05/17/13, included the following interventions: "Assess food likes and dislikes, Encourage meal/fluid intake and record, Monitor labs as available, Monitor skin daily during care, Provide pericare as needed, Provide pressure reducing device to bed, Provide pressure reducing device to chair and Skin assessment at least weekly by nurse."</p> <p>Interview with Resident #C, on 08/26/13 at 1:30 P.M., indicated when he was first admitted to the facility he spent most of his time siting up in his wheelchair. He indicated it had a thin cushion with "liquid" of some kind in the cushion. He indicated he wore socks when he was up in the wheelchair.</p> <p>Review of the electronic weekly nursing assessments, indicated for</p>		<p>to promote healing, prevent infection and prevent new sores from developing. Resident #C remains in the facility. Currently is being treated for wounds to the bilateral heels. Resident is being followed by the wound clinic. Care plans have been reviewed and updated. All residents have the potential to be affected by this deficient practice. All resident's reviewed to ensure those at risk for breakdown are identified and appropriate measures are in place to prevent skin breakdown.</p> <p>All residents are assessed upon admission for skin issues and risks for skin breakdown. The plan of care is then developed and is reflective of these assessments. The skin is assessed daily every shift for 3 days, then at least daily for 14 days, then no less than weekly thereafter. The physician and POA are notified of any changes noted in skin integrity. The care plan is updated accordingly with changes. The facility will re-educate all nursing staff 9/20/13 regarding the policy for skin assessment, identifying risks and prevention of breakdown. To ensure that all residents identified as risk for breakdown have proper preventative measures in place upon admission the facility wound nurse will complete the QA Tool "Pressure Ulcer Risk/Reduction and Treatment Review" (Attachment #4) on all new</p>		

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	<p>06/19/13 and 06/26/13, the box to mark if the skin was assessed was not checked.</p> <p>An assessment, titled, "Nursing- New Skin Alteration Assessment," completed on 07/25/13, indicated the resident had new wounds. The description of the wounds indicated the following: "Area noted to outer left heel measuring 4.0 cm by 5.2 cm. Area is nonblanchable. Edges appear black. Appears fluid filled. Center is purple. Area noted to right heel. Area with hard and peeling skin. No redness or drainage noted."</p> <p>On 08/26/13 at 1:30 P.M., the heels and buttocks of Resident #C were observed with Wound nurse, LPN #10. The right heel had a pencil eraser sized brownish/purplish hard area on the middle of the bottom of the heel. The outer edge of the left heel had a quarter sized shiny black area with an rectangular shaped purple area to the side and connected to the black area. Neither area was open. LPN #10 indicated both heel areas were hard to touch and were being treated with foam padding and kerlix. She also indicated the resident was wearing blue padded boots and was in bed now except for meal and when walking with restorative.</p>		<p>admissions for the next 30 days, then on 10% of the resident population and all residents identified with pressure ulcers on a monthly basis thereafter. Any identified issues will be addressed immediately. Any concerns will be documented on the QA Summary Log. This will be followed and reviewed in QA monthly and any needed changes will be implemented by the QA Team. Date of Compliance: 9-25-13</p>				

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	<p>Interview with Resident #C and LPN #10, on 08/26/13 at 1:30 P.M., indicated he had worn the boots for the about the past month since he had been spending more time in his bed. There was no indication specific interventions to protect he resident's heels were in place prior to the development of his heel pressure areas.</p> <p>This Federal tag relates to Complaint #IN000135315</p> <p>3.1-40(a)(1)</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, record review and interview, the facility failed to ensure the mattresses fit the bed frames for 2 of 35 residents reviewed for accident hazards. (Resident #14 and #137)</p> <p>Findings include:</p> <p>1. The bed for Resident #14 was observed on 08/20/13 at 2:50 P.M.. The mattress was noted to be against the bottom of the bed frame snugly, however, there was a large gap between the top of the mattress and the headboard of the bed. Interview with Resident #14, who was seated in her recliner, indicated she did sleep in the bed at night.</p> <p>Resident #14's bed observed, on 08/22/13 at 2:28 P.M. The head of the bed and the top of the mattress fit snugly. There was a rolled blanket noted at the foot of the bed between the foot board and the bottom of the mattress. Interview with Resident #14 indicated she does sleep in her bed</p>	F000323	F-Tag 323 Free of Accident Hazards/Supervision/Devices: It is the policy of Miller's Merry Manor, Plymouth to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents. Residents #14 and #137: Residents were not harmed by the deficient practice. On 8/20/13 after discovery the facility immediately corrected the identified hazards. All resident are at risk to be affected by deficient practice. On 8-20-13 the facility administrative staff immediately completed walking rounds of all units to inspect mattress/bed surfaces for proper fit to bed frame. All beds in use were identified as having proper fitting mattress in place. Mattresses were ordered and received for some unoccupied beds that did have shorter mattresses on them. All facility staff will be in-serviced on 9-20-13 regarding properly fitting mattresses and monitoring bed safety. Administrator/Designee will be responsible to ensure new mattresses are properly installed	09/25/2013	

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	<p>and did not consider herself a restless sleeper. Resident is noted to be confused at times.</p> <p>The clinical record for Resident #14 was reviewed on 08/21/13 at 11:00 A.M. Review of nurse's notes, since admission did not indicate resident had any falls since admission.</p> <p>Interview with RN #6 and LPN #12, on 08/22/13 at 2:50 P.M., indicated the resident had not fallen, was restless sometimes and fixated on things such as "I need to go to the bathroom" or "I'm bored."</p> <p>2. The clinical record for Resident #137 was reviewed on 08/21/13 at 9:30 A.M. Resident #137 was admitted to the facility on 07/25/13 with diagnosis, including but not limited to gastrointestinal tract hemorrhage, congestive heart failure, chronic obstructive airway disease, diabetes, hyperlipidemia, hypertension, atrial fibrillation, and esophageal reflux.</p> <p>The admission Minimum Data Set (MDS) assessment, completed on 08/01/13, indicated the resident was alert and oriented and required limited staff assistance for bed mobility and transfer needs.</p>		<p>and fitted to bed frame prior to resident use. Staff will be instructed to report any gaps, ill fitting mattresses, loose side rails etc... immediately upon discovery for repair/replacement. Housekeepers will also participate in inspection of the mattress and security of side rails weekly with deep cleaning of bed frame/mattress. The Administrator/Designee will be responsible to complete the QA tool titled "General Observations of the Facility Review" (Attachment 5) weeklyx4 weeks, then monthly thereafter to ensure ongoing compliance. Any identified issues will be immediately corrected and documented on facility QA Summary Log. Logs are reviewed during the monthly facility Quality Assurance Performance Improvement meeting to ensure ongoing compliance. . Date of completion: 9/25/13</p>		

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	<p>Review of the nursing progress notes and the assessments for Resident #137, from his admission on 07/25/13, to his discharge from the facility on 08/21/13 indicated he did not have any falls and no incidents or injuries due to the gap between the bed frame and the mattress.</p> <p>Interview with RN #6 and LPN #12, on 8/22/13 at 2:50 P.M., indicated the facility had gotten new beds when the rehab unit was updated but the mattresses were not new and some did not fit the beds correctly. RN #6 indicated she thought the Administrator was going to either have the corporation buy permanent bolsters or get new mattresses that were the correct length.</p> <p>Interview with the Administrator, on 08/22/13 at 3:00 P.M. indicated there were several beds with mattresses too short. She could not member exactly how many. She indicated blanket bolsters were put in place as a temporary fix but she was going to ask the corporate office to order 5 - 10 new mattresses the appropriate length to fit the beds.</p> <p>Documentation provided on 08/23/13 at 10:17 A.M., by the Administrator</p>				

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	<p>and interview with the Administrator, indicated there were actually only 4 resident beds/mattresses found with large gaps. She indicated the mattresses were 78 inches long and the bed frames were 84 inches long. This allowed a potential of 6 inch gaps. She indicated there had been no falls or injuries in the facility related to the gaps between the mattresses and the bedframes.</p> <p>3.1-45(a)(1)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interview, the facility failed to ensure there was adequate monitoring of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #102) In addition, the facility failed to provide adequate justification to support an increase in the psychoactive medications for 2 of 5 residents reviewed for unnecessary medications. (Resident #102 and</p>	F000329	F-Tag 329: Unnecessary Medications: It is the policy of Miller's Merry Manor, Plymouth that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose, without adequate indication for use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of reasons. Resident #102 and #113: Medication regimen has been reviewed by physician to ensure	09/25/2013			

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	<p>#113)</p> <p>Findings include:</p> <p>1. Resident #102 was observed, on 08/22/13 at 1:28 P.M., ambulating into the day room on the secured dementia unit. Resident ambulated by herself with no walker, walked a little stiffly, sat down in a recliner and shut her eyes.</p> <p>Resident #102 was observed, on 08/23/13 at 9:20 A.M., seated in the lounge on unit asleep. At 9:30 A.M., Resident woke up and stood up and walked down the hall. Resident was noted to be slightly unsteady as she walked and once in hall, did use the handrail. Resident indicated she needed to get some medication that she had ran out of and needed to reorder it. Two staff members kept trying to use reality orientation and Resident #102 became increasingly agitated indicating she did not believe she did not have to order her medication. Resident told one of the staff to "quit ordering me around." Staff did offer resident "yahtzee" to play with other residents. Resident finally agreed to wait for the "nurse" to talk to her about her medications. Resident agreed to sit in a chair and promptly fell back asleep. At 10:04</p>		<p>that resident is free from unnecessary medication. The HCP team has reviewed and updated residents behavior management programs to ensure psychosocial needs of resident are being met.. Facility policy and procedure for GDR will be followed. All residents who are prescribed psychoactive medications are at risk to be affected by the deficient practice.</p> <p>The nurse managers will complete an audit of all active residents to ensure proper indication and diagnosis for use of any prescribed psychoactive medications by 9/25/13. The pharmacy consultant will continue to make monthly visits to complete onsite drug regimen reviews and will submit recommendations for drug reductions to the DON. The DON or other designee will be responsible to communicate pharmacy recommendations to the physician and ensure timely physician response/follow up. The facility policies for "Behavior Assessment/Management Program" (Attachment #6) and "Psychotropic Drug Use" (Attachment #7) will be reviewed with all nursing staff by 9/20/13.</p> <p>The facility will have monthly behavior meetings to review residents who are prescribed Psychoactive and psychopharmacological medications, behavior patterns/target behaviors,</p>		

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	<p>A.M., staff woke the resident up and walked her to the dining room table for a snack.</p> <p>The clinical record for Resident #102 was reviewed on 08/22/13 at 1:00 P.M. Resident #102 was admitted to the facility on 06/06/12, with diagnoses, including but not limited to Alzheimer's disease, dementia with behavioral disturbances, psychosis, osteoporosis, osteoarthritis, episodic mood disorder, depressive disorder, diabetes, chronic airway obstructive disease, hypertension, anxiety disorder, insomnia, anorexia, panic disorder without agoraphobia, and aphasia.</p> <p>Her admission physician orders for medications, on 06/06/12, included orders for the antipsychotic medication, Geodon 20 mg (milligrams) to be given three times a day for panic disorder/psychosis.</p> <p>The Quarterly Behavior Medication Review meetings, on 09/20/12, indicated the resident was restless and had displayed anger towards staff. There was no documentation of delusional or psychotic behavior.</p> <p>On 11/14/2012 at 12:45 P.M., a physician order was received to</p>		<p>pertinent diagnosis for use, and ensure physicians are notified of any pharmacy recommendations for GDR's. Resident specific interventions will be reviewed for effectiveness and changes will be made as needed to the resident's plan of care. The charge nurses will be instructed to document new onset of behavioral symptoms or worsening symptoms in the EMR and on the Pertinent Charting Sheet. The Pertinent Charting Sheet will serve as a communication tool and is reviewed routinely by the nurse management team to ensure prompt intervention by the HCP for the new onset of behavior/worsening behaviors and to monitor for unnecessary medication orders.. Resident specific behavior programs and the interventions in plan of care to prevent/reduce the frequency of target behaviors etc. will be communicated in the EMR/POC documentation.</p> <p>Behavior episodes will be documented in the EMR along with the effectiveness of the health care plan interventions each shift and prn. The QA Tool "Behavior and Antipsychotic Medication Review" (Attachment #1) will be utilized to ensure that the standard is met. This tool will be completed on 25% of all residents receiving psychoactive medications by SS/Designee weekly x4 then quarterly thereafter. All issues identified will</p>		

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	<p>decrease the residents Geodon medication to 20 mg twice a day instead of three times a day.</p> <p>A nursing note, dated 11/16/2012 at 23:26 (11:26) P.M., indicated the resident was pacing the unit aimlessly and restless, not willing to go to sleep, she states she had no pain or discomfort. Nursing notes, on 11/17/12, indicated the resident had been transferred to the emergency room, diagnosed with pneumonia and placed on an antibiotic.</p> <p>On 03/26/13 at 12:48 P.M., a nurses note indicated the resident was seen by the psychiatric consultants and the times of one of the Geodon doses was changed from 5 P.M. to 3 P.M. in an attempt to improve "anxiousness and agitation in the early evening."</p> <p>A physician's order, received on 04/18/13, indicated the times for the twice a day Geodon administration were changed to 2 P.M. and 10:00 P.M.</p> <p>A physician's order, received on 04/25/13, discontinued the 2:00 P.M. dose of Geodon.</p> <p>Review of the behavior tracking for "restlessness" for Resident #102,</p>		<p>be addressed immediately. Any problem or concerns will be noted on the monthly QA Summary log. This will be reviewed in the monthly QA Meeting. Date of Completion 9/25/13.</p>				

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	<p>from April 25, 2013 - May 8, 2013, indicated there were 13 shifts where the resident was documented as "restless," however, the behavior improved with the nonpharmalogical interventions in 12 of the 13 episodes.</p> <p>A nurses note, on 5/2/2013 at 22:30 (10:30 P.M.), indicated the following: Resident has been very upset this shift. She came out of room at 8:30 shaking and in tears stating, "I have done something wrong. I don't know what I did, I really want to stay here but I am in big trouble." Staff tried to reassure resident that everything was okay but resident insisted that she did something wrong. At 9:30P writer called (nurse practitioner's name from psychiatric center)."</p> <p>A nurses note, dated 5/8/2013 at 9:05 A.M. indicated the following: "Since Remeron, an antidepressant also used to stimulate appetite, restarted resident is now eating well, no c/o [complaints] n/v [nausea or vomiting], and is up participating in activities. Resident is becoming more anxious, exit seeking and looking for husband. Yesterday resident was shaky around 3pm worrying about husband and where he was. Angry that another resident lives in her room states that is where her husband sleeps,</p>				

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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 635 OAKHILL AVE PLYMOUTH, IN 46563		
(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	
	<p>[husband is deceased and resident has not been asking for him over 3 months]. A dose of geodon had been discontinued on 4/25/2013. Will notify [nurse practitioner's name from the psychiatric center]."</p> <p>A physician's order, dated 05/08/13, increased the Geodon from 20 mg once a day back to 20 mg twice a day at 2 P.M. and 8 P.M. There was no documentation the resident had been delusional and/or psychotic.</p> <p>Nursing progress note, dated 05/21/13 at 14:56 P.M., indicated the resident had no behaviors. The next nursing note, dated 06/07/13, indicated the resident was agitated at shift change and her behavior was escalating. The note indicated the resident was upset that there were other people in her home. A physician's order was received to administer the antianxiety medication, Ativan .5 mg every hour. The note indicated the resident took the Ativan medication and at 1:00 A.M. was sleeping and calm.</p> <p>The next nursing note, dated 06/07/13 at 14:42 indicated the resident had no behaviors and had been cooperative. However, orders were received from the psychiatrist.</p>				

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	<p>The order, from the psychiatric center, dated 06/07/13, increased the Geodon from 20 mg twice a day to 20 mg three time a day.</p> <p>Interview with RN #11, the unit manager, on 08/23/13 at 9:45 A.M., indicated Resident #102 would start to pace and want to go home in the afternoon. She indicated in the past, the resident had actually broken an exit door trying to get out of the unit. She indicated the resident thought the dementia unit was "school" and in the afternoon thought she should go home to her parents. She would also at times refuse to eat the meals because she wanted her "packed lunch from her locker." She would also sometimes think the unit was her "home" and get upset because there were other people (residents and staff) in her home or room. RN #11 indicated at times Resident #102 would get so upset she would "shake." When asked about behavior monitoring, RN #11 indicated only the "restlessness" was being monitored. The interventions on the form included the following interventions: "1. talk with 1:1 to validate feelings 2. Offer diversional activity such as snack and drink 3. Reminisce with resident with items</p>			
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	<p>that her family brought 4. Provide comfort and reassurance." RN #11 indicated she sometime gave the resident worksheets to complete or a basket of socks to mate when she became restless.</p> <p>Interview with the Social Service Director, Employee #13, on 08/22/13 at 2:20 P.M., indicated the electronic charting system was set up so per shift staff were able to document if a resident displayed the behavior being monitored and if the behavior improved or was unchanged with interventions. He indicated the system did not allow the employee to document how the resident displayed the behavior, which interventions they had tried, and there was no way to tell which interventions were helpful. He indicated he expected the staff to "go down the list of interventions, starting with the first intervention listed to address behaviors." He confirmed the only behavior monitored for Resident #102 was "restlessness." He also indicated he would consider Resident #102's habit of thinking she was at school or in her own home an aspect of her dementia not necessarily a delusion or psychosis.</p> <p>In addition, review of the nursing assessments related to falls for</p>				

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	<p>Resident #102 in the past year indicated she had fallen on 11/18/12, and had not fallen again until 06/24/13. After the Geodon medication was increased on 06/07/13, Resident #102 had fallen five times.</p> <p>2. The clinical record for Resident #113 was reviewed on 08/22/13 at 1:15 P.M. Resident #113 was admitted to the facility on 01/01/13, with diagnoses, including but not limited to, senile dementia, diabetes, anxiety disorder, dementia with behavioral disturbances, hyperlipidemia, emphysema, chronic airway obstruction, hypertension.</p> <p>The current medication orders for Resident #113 included the antianxiety medication, Lorazepam .5 mg to be given twice a day for anxiety and the antipsychotic medication, Risperidone .25 mg 1/2 tab twice a day.</p> <p>On 07/09/13, the physician discontinued the routine Lorazepam. However, on 07/17/13, nursing notes documented Resident #113 as having an excessive laughing episode which prevented the resident from completing her ADL's (activities of</p>			

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	<p>daily living) and indicated she became agitated with verbal cues. A physician's order was received, on 07/17/13, for a one time order of Lorazepam, which was effective.</p> <p>On 07/18/13, a physician's order was received to restart the resident's routine Ativan. Interview with RN #11, the dementia unit manager, on 08/22/13 at 10:00 A.M., indicated Resident #113 did show a change in behavior when her Ativan was discontinued but there was no documentation of the behavior, except in the one time charting of excessive laughing and the daily documentation regarding her physical behaviors of hitting, kicking, and pinching staff during care. There were no documented episodes of the physical behaviors from 07/09/13 - 07/16/13. There was one episode, on 07/17/13, on the night shift. There was no explanation given by RN #11 as to how Resident #113 displayed her anxiety and what interventions the facility utilized to respond to her anxiety.</p> <p>The Risperdone medication for Resident #113 was ordered upon her admission to the facility on 01/01/13, for Dementia with behavioral disturbances. Review of the</p>				

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	<p>behavioral monitoring for Resident #113 related to the Risperdone use indicated the physical behaviors of hitting, kicking, and pinching staff were being monitored. The resident displayed 5 behaviors in January 2013 and all behaviors improved with interventions, she displayed one behavior in February 2013 and it also improved with inventions, she did not display any behavior issues in March, April, May or June 2013. There was no indication the physician was approached regarding a gradual dose reduction until 08/06/13. He refused the suggestion from pharmacy stating the resident had a prior reduction which resulted in increased agitation and restlessness. Interview with the Director of Nursing, on 08/23/13 at 2:00 P.M., indicated they were going to reapproach the physician because the resident had not had a reduction in her Risperdone, only a failed attempt with antianxiety medication, Ativan.</p> <p>3.1-48(a)(6)</p>				

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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 635 OAKHILL AVE PLYMOUTH, IN 46563
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F000356 SS=C	<p><b>483.30(e) POSTED NURSE STAFFING INFORMATION</b></p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to post the current daily resident census and the total/actual hours worked for licensed and unlicensed nursing staff on the "Daily Nurse Staffing Form" for</p>	F000356	F356 Nurse Staffing Information: It is the policy of Miller's Merry Manor, Plymouth that the facility will post the following information on a daily basis: Facility name, the current date, the total number and actual hours worked by the	09/25/2013			

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	<p>5 of the 5 days the posting was observed. (8/20, 8/21, 8/22, 8/23 and 8/26/13)</p> <p>Findings include:</p> <p>The "Daily Nurse Staffing Form" was observed and reviewed during the 5 days of the survey from 8/20 through 8/26/13. The posting included the total number of RN's (Registered Nurses), LPN's (Licensed Practical Nurses), and CNA's (Certified Nurse Aides). The posting did not include the daily resident census or the actual/total hours worked at the start of each shift for the days of 8/20, 8/21, 8/22, 8/23 and 8/26/13.</p> <p>During an interview on 8/26/13 at 9:20 A.M., the ADON (Assistant Director of Nursing) indicated she was the one responsible for these forms and, when the staffing form is printed before the start of the day, the census number is not populated. The ADON further indicated she looks at the staff punch card hours before she fills in the actual hours worked.</p> <p>3.1-13(a)</p>		<p>following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift (RN's, LPN'ss and CNA's), and the resident census. The "Daily Nurse Staffing Form" is completed on a daily basis by the ADON/Designee and is located in area that is readily accessible to residents and visitors. Staff responsible for the posting of the report have been re-educated on the information that is required to be posted. Scheduled hours will be listed, the date, and the current resident census. The QA tool "Nursing Services Review"(Attachment # 8) will be utilized to ensure that the Daily Staffing Nursing Form is posted daily with the accurate information to meet required guidelines. This form will be completed 2x weekly for 2 weeks then weekly x 2 weeks and then quarterly thereafter. Any concerns issues will be addressed and logged on the Monthly QA Summary Log. This will be reviewed and discussed in the monthly QA meeting. Date of Compliance: 9-25-13</p>		

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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 635 OAKHILL AVE PLYMOUTH, IN 46563
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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>1. Based on observation, interview and record review, the facility failed to ensure resident food was served in a sanitary manner related to adequate hand washing by 3 employees in 1 observed dining room. (Dietary Aide #1, Dietary Aide #2, and RN #3) This had the potential to affect 82 of 82 residents who received meals from 1 of 1 kitchen.</p> <p>2. Based on observation, interview and record review, the facility failed to store food under sanitary conditions. This had the potential to affect 82 of 82 residents who received meals from 1 of 1 kitchen.</p> <p>3. Based on observation, interview, and record review, the facility failed to ensure the kitchen equipment was clean and sanitary, related to a dirty meat slicer and dirty plastic carts. This had the potential to affect 82 of 82 residents who received meals from 1 of 1 kitchen.</p>	F000371	<p>F-Tag 371 Food Procure, Store/Prepare/Serve-Sanitary It is policy of Miller's Merry Manor that all food be prepared and served in a clean, sanitary, and safe manner to conserve maximum nutritive value, develop and enhance flavor, and be free of injurious organisms and substances. On 9/4/13 all Dietary Staff was in-serviced on Hand washing, Food Protection, Sanitation and Outdated Food. All three employees observed in Dining Room on the Rehab Unit were re-educated on facility Hand Washing Policy. These employees were serving on the Rehab Unit and had potential to 8 of 82 residents who received meals from that kitchen. The 4 cheese sandwiches were disposed of immediately. Cleaning Schedule for position, "Day Prep" (Attachment #9 pg. 1 of 7) was modified to include "Check outdated items in refrigerators and discard if outdated". 3.A. Meat slicer was cleaned and cleaning schedule for position, "Day Prep" was modified to include "Sanitize Slicer" (Before and After use). B. Two new carts were purchased</p>	09/25/2013

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	<p>Findings include:</p> <p>1. During a lunch observation on 8/20/13 in the Rehabilitation Unit dining room the following were observed:</p> <p>At 12:15 PM, Dietary Aide #1 was observed to wash her hands for 9 seconds and then prepare resident food plates.</p> <p>At 12:16 PM, Dietary Aide #2 was observed to wash her hands for 11 seconds, place prepared food containers on the steam table and then at 12:17 PM wash her hands for 9 seconds.</p> <p>At 12:24 PM, RN #3 was observed to wash her hands for 12 seconds.</p> <p>On 8/23/13 at 11:00 AM, review of the current "...Infection Control Manual...Hand washing..." policy received from the DON indicated "...to ensure that hands remain clean so as to...assist in the prevention of and the transmission of disease and infection...procedure:...rub vigorously for at least 20 seconds...."</p> <p>On 8/26/13 at 10:27 AM, interview with the Certified Dietary Manager (CDM) indicated dietary staff were</p>		<p>and old carts were disposed of. Cleaning Schedules for all positions in Dietary were modified to include "Carts" (Attachment #9 -7pages). All residents could have been, but were not affected by the deficient practices. QA Tool "Dietary Food Safety Sanitation Checklist" (Attachment #10) will be completed weekly for four weeks and then monthly there after by the dietary manager. Any concerns/issues will be addressed and logged on the Monthly QA Summary Log. This will be reviewed and discussed in the monthly QA meeting. Date of Completion 9/25/13</p>				

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	<p>instructed to wash hands for 20 seconds before serving food out on the unit dining rooms.</p> <p>2. On 8/20/13 at 10:00 A.M., during the kitchen tour with the Dietary Manager, the following was observed: inside the walk in cooler 4 cheese sandwiches were observed in a metal pan with plastic wrap over the top of the pan. The date of 8/14/13 was written in marker on top of the plastic.</p> <p>On 8/20/13 at 10:05 A.M., an interview with the Dietary Manager indicated left overs are kept for 3 days only and the cheese sandwiches would be disposed of immediately.</p> <p>On 8/22/13 at 3:00 P.M., record review of the current policy titled "Food Protection and Storage" received from the Dietary Manager indicated "...It is policy that all foods shall be stored and protected under safe and sanitary conditions...Planned left over food is stored in covered shallow containers 2" or less in depth or in zip lock bags laid flat on a tray or wrapped carefully and securely, clearly labeled and dated. Any left over foods not frozen need to be used within 3 days or discarded...."</p> <p>3. On 8/20/13 at 10:10 A.M., during</p>			

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	<p>the kitchen tour with the Dietary Manager, the following was observed:</p> <p>a. The meat slicer was stored as clean, and had a cover over the top of it, upon removal of the cover it was observed to have a dried green substance on the bottom of the slicer.</p> <p>b. 2 plastic carts, one cart had 2 loaves of bread on the top tray, and the other cart had a tablecloth on the bottom tray. Both carts were observed to have a brown/red sticky substance in all 4 corners and on the outside edges of the bottom tray.</p> <p>On 8/20/13 at 10:15 A.M., an interview with the Dietary Manager indicated the green substance on the meat slicer looked like a piece of dried lettuce and was unsure how it got there but would have it cleaned immediately. The Dietary Manager further indicated the plastic carts are to be cleaned before and after each use, but the carts are old making it hard to clean them and that she was going to dispose of the carts and purchase new ones.</p> <p>c. On 8/21/13 at 9:45 A.M., the meat slicer was stored as clean and had a cover over the top of it, upon removal of the cover it was observed to have a</p>				

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	<p>green/yellow crust around the bottom corner of the slicer. The Dietary Manager attempted to scrape the crust away with her fingernail and indicated it would take a knife to clean the substance out of the crevice.</p> <p>On 8/22/13 at 2:30 P.M., an interview with the Dietary Manager indicated the meat slicer is only used and cleaned on Wednesdays after use. The Dietary Manager further indicated she was going to implement a new cleaning schedule that indicates the slicer will be cleaned before and after each use.</p> <p>d. On 8/22/13 at 3:00 P.M., record review of the current policy titled "Equipment and Utensils-Cleaning and Sanitizing" received from the Dietary Manager indicated "...A. The Dietary Manager will check for the following: II. All...equipment is kept clean, maintained in good repair and is free from breaks, corrosions, open seams, cracks, and chipped areas...B. The food contact surfaces of all equipment and utensils are sanitized by: I. Immersion for at least 60 seconds in clean, hot water at a temperature of at least 170 degrees F; or immersion in a clean solution containing a chemical sanitizing agent... II. Run through dish machine.</p>				

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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 635 OAKHILL AVE PLYMOUTH, IN 46563		
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	<p>C. After sanitization, all equipment and utensils are air-dried, then handeled and stored in a manner which will protect them from contamination...."</p> <p>This federal tag relates to Complaint IN00134769.</p> <p>3.1-21(i)(3)</p>				

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000441	F441 Infection Control: It is the policy of Miller's Merry Manor,	09/25/2013			

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	<p>perform hand hygiene before and after administering medications for 3 of 8 resident's observed during a medication pass. (Resident # 27, Resident #111 and Resident #4)</p> <p>Findings include:</p> <p>On 8-23-13 at 1:16 P.M., RN #9 was observed walking into Resident #27's room to complete a breathing treatment. RN #9 listened to Resident #27's lung sounds, touching resident's clothing and skin with her hands. RN #9 returned to the medication cart and prepared medications for Resident #111. RN #9 went into Resident #111's room and administered the medications and returned to medication cart. RN #9 then set up medications for Resident #4 and administered the medication. RN #9 returned to the cart and washed hands with alcohol gel.</p> <p>During an Interview, on 8-23-13 at 1:25 P.M., RN #9 indicated she should have washed her hands before and after each medication pass.</p> <p>On 8-23-13 at 2:45 P.M., a policy titled "Medication Administration Procedure" indicated the nurse was to</p>		<p>Plymouth to establish and maintain an Infection Control Policy designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Resident #27, #111, and #4 suffered no adverse effects related to this deficient practice. All residents have the potential to be affected by this deficient practice. No other issues have been identified. RN #9 was re-educated regarding handwashing during medication pass. Education will be provided to all staff on 9-20-13 to review infection control policies with focus on handwashing. The facility does provide routine education per on line inservices (Silverchair) and face to face education on infection control. Routine skill checks are also done for handwashing. Skill checks for staff on handwashing will be completed monthly for the next three months. To ensure that infection control measures are followed according to policy and procedure, the QA Tool "Infection Control" (Attachment #11) will be completed by the Infection Control Nurse/Designee weekly for the next four weeks and then monthly thereafter. Any identified issues will be addressed immediately. Concerns will be logged on the QA summary log. All logs are reviewed and followed by the QA</p>		

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	"...perform hand hygiene..." prior to preparing the medication for administration and remain with the resident until each medication was swallowed, then "...perform hand hygiene, leave the patient in a comfortable position...."  3.1-18(l)		Committee in the monthly QA Meeting. Date of Compliance: 9-25-13	

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F000465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to provide a clean environment, free from food stains and food particles on the upholstery and crevices of the main dining room chairs. This had the potential to affect 57 of 82 residents who eat in the main dining room.</p> <p>Findings include:</p> <p>On 8/23/13 at 1:30 P.M., during an environmental tour with the Maintenance Supervisor, the Administrator in Training, and the Environmental Service Director, the following was observed in the main dining room:</p> <p>Dried food stains on the back and the seat of an upholstered chair and dried food in the crevices of 2 additional dining room chairs.</p> <p>On 8/23/13 at 1:40 P.M., an interview with the Environmental Service Director (Employee #7) indicated the chairs in the main dining room are to be cleaned by the housekeeping department every 3rd Friday, but they</p>	F000465	<p>F465 Safe/Functional/Sanitary/Comfortable Environment: It is the policy of Miller's Merry Manor, Plymouth to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This deficient practice has the potential to affect all residents in the facility. The dining rooms chairs were thoroughly cleaned on 8/24/13 by Housekeeping Staff. Housekeeping Staff will also be re-educated on addendum to the policy for cleaning the dining room. When cleaning the dining rooms, they will be required to check all dining room chairs and clean as needed. The QA Tool "Housekeeping Services Review" (Attachment #12) will be utilized to monitor and ensure that the DR furniture is kept clean and comfortable. The Housekeeping Supervisor and/or designee will complete this tool one time per week for four weeks and monthly thereafter. Any identified issues will be addressed immediately. Concerns will be logged on the QA summary log. All logs are reviewed by the QA committee in the monthly QA meeting. Date of Compliance: 9/25/13</p>	09/25/2013			

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	<p>are to visually look at them daily when they clean the floors and wipe down the chairs when needed. Employee #7 further indicated the chairs looked bad and needed to be cleaned.</p> <p>On 8/26/13 at 9:30 A.M., record review of the current policy titled "Dining Rooms" received from the Administrator in Training indicated "...Purpose: To provide a very clean and sanitary environment and esthetically attractive area for the residents to eat their meals...7) Wash down chairs and table legs, as needed, and at least monthly...."</p> <p>This federal tag relates to Complaint IN00134769.</p> <p>3.1-19(f)</p>			