

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2011
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN46173
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F0000	<p>This visit was for the Investigation of Complaint IN00100626.</p> <p>Complaint IN00100626 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-224, F-225, F-226, and, F-332</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: December 12, 13, 14, and 15, 2011</p> <p>Facility number: 000018 Provider number: 155053 AIM number: 100273930</p> <p>Survey team: Sharon Lasher, RN, TC Angel Tomlinson, RN Barbara Gray, RN (December 12 and 13, 2011) Leslie Parrett, RN</p> <p>Census bed type: SNF: 7 SNF/NF: 63 Residential: 20 Total: 90</p> <p>Census payor type: Medicare: 8</p>	F0000		

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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F0166 SS=D	<p>Medicaid: 52 Other: 30 Total: 90</p> <p>Sample: 5 Supplemental sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/20/11 by Jennie Bartelt, RN.</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on interview and record review, the facility failed to address a grievance of the family of 1 of 1 resident reviewed related to grievances in a sample of 5. (Resident #A)</p> <p>Findings include:</p> <p>The clinical record of Resident #A was reviewed on 12/13/11 at 10:00 a.m. The record indicated Resident #A's diagnoses included, but were not limited to, anoxic (deficiency of oxygen) brain damage, closed dislocation first cervical vertebra</p>	F0166	DON attended a meeting requested by Resident #A's family member on 12.12.11 and at that time was made aware that the timeliness of suctioning from one specific nurse had not improved. DON addressed the concern of Resident #A's family member with the nurse referenced in the complaint.No other residents have been affected by this deficiency as no other residents currently require suctioning. DON instructed to use a written Resident/ Family Concern Record when a complaint is voiced. DON instructed to ask questions	01/10/2012	

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	<p>and quadriplegia.</p> <p>During interview on 12/12/11 at 9:00 p.m., Resident #A's family member indicated he had informed the Director of Nursing (DON) on 11/23/11, about one nurse that always took an hour or more to come to the room to suction (Resident #A) after being asked to suction her. The family member also indicated the DON had not followed up with the problem he had asked her about.</p> <p>During an interview with the DON on 12/12/11 at 9:10 p.m., the DON indicated she had not put the complaint (of the nurse taking over an hour to suction the resident) in writing and had not followed up with the family member regarding the the delay in Resident #A's being suctioned.</p> <p>A document titled "Grievance Procedure" dated 5/25/06, provided by the DON on 12/13/11 at 2:10 p.m., and indicated by the DON to be the most current policy indicated, "Procedure, Grievances submitted to the designated staff will be copied and given to the appropriate department head for resolution and to the administrator for his/her information. The Social Services Director will assist the facility administrator in reviewing the status of all grievances, weekly."</p>		<p>specific in nature to the complaint when following up with a resident or resident family member regarding a concern previously voiced. DON re-educated on the facility Grievance Policy and Procedure and follow up on resident/ family concerns. All staff inservice held on 12.22.11 to re-educate on the importance of written documentation of concerns using the Resident/ Family Concern Record and specific follow up to assess for further concerns. Corrective action will be QA monitored using the Grievance Follow-Up tool. This QA tool will be used by Administrator, Social Services or Designee daily x 4 weeks, then weekly x 4 weeks, then monthly x 6 months to ensure all concerns voiced to the DON have been documented and follow up specific in nature to the previous concern has occurred. This process will be monitored using the Quality Improvement Tool-Grievance Follow Up Review. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.</p>		

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F0224 SS=D	<p>3.1-7(a)(2) 3.1-7(b)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview and record review the facility failed to ensure that one resident did not experience rough treatment for 1 of 6 residents in a sample of 5 and supplemental sample of 3 reviewed for rough treatment. (Resident #A)</p> <p>Findings include:</p> <p>The record of Resident #A was reviewed on 12/13/11 at 10:00 a.m. The record indicated Resident #A's diagnoses included, but were not limited to, anoxic (deficiency of oxygen) brain damage, closed dislocation first cervical vertebra and quadriplegia.</p> <p>Resident #A's Minimum Data Set (MDS)</p>	F0224	Resident #A was fully assessed and no evidence of injury or distress was noted. Resident #A's Physician was updated and the care plan was updated to indicate that prior to providing Resident #A care, staff should explain what they are doing and encourage the resident to relax and approach her slowly, especially with peri care. Social Services attempted to communicate with Resident #A to assess for any signs of distress-no evidence of distress, negative outcome or changes in Resident #A were noted. CNA #1 was placed on suspension pending an investigation. All 36 residents on East wing and all 35 residents on West wing were either directly questioned or physically observed for signs of distress by Administrative/	01/10/2012	

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	<p>dated 10/26/11 indicated the following:</p> <ul style="list-style-type: none"> <li>- speech clarity, no speech</li> <li>- makes self understood, rarely/never understood</li> <li>- ability to understand others, rarely/never understands</li> <li>- brief interview for mental status, resident was unable to complete the interview</li> <li>- transfer, total dependence</li> <li>- walk in room or corridor, activity did not occur</li> <li>- dressing, total dependence</li> <li>- incontinent of bladder and bowels</li> </ul> <p>Resident #A was observed on 12/12/11 at 8:00 p.m., in bed on left side, with gastric-tube feeding infusing, tracheotomy in place, eyes open, and unable to speak</p> <p>On 12/12/11 at 8:45 p.m., a family member of Resident #A requested a meeting that would also include the DON and Administrator. During the meeting, the family member indicated it was reported to him by an anonymous employee at the facility on 11/28/11, that a CNA grabbed Resident #A's legs open in a rough manner. The family member indicated the rough treatment was reported to the DON by the staff and Resident #A had a chunk out of her leg, multiple bruises and a scratch on her face the day it happened. The family member</p>		<p>Nursing staff to assess for concerns regarding rough treatment by staff. All nursing staff on duty were also interviewed to determine if they were aware of any resident mistreatment. All staff on duty from initial allegation received on 12.12.11, including department heads and Therapy, have been re-educated on the Abuse Prohibition Policy and Procedure, definitions of abuse and process for reporting abuse and/ or allegations of abuse. All remaining staff have been re-educated on the Abuse Prohibition Policy and Procedure, definitions of abuse and process for reporting abuse and/ or allegations of abuse on 12.22.11. Staff receive Abuse Prohibition Policy and Procedure upon hire, quarterly and as needed. The Vice President of Quality Assurance and Regional Quality Assurance Nurse have been informed of the allegations of abuse and the concerns reported from the ISDH, a CNA and Resident A's family member. The Administrator and DON have been re-eduated on their role in the Abuse Prohibition Policy and these roles have been clearly defined and reviewed and will be monitored to assure compliance has been maintained. Medical Director Dr. Richard Boersma, MD was informed of the previously listed allegations and concurs with the plan of</p>		

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	<p>stated, "I felt I should have been notified of the rough treatment, but I was not notified of the rough treatment." The Administrator indicated at the time the incident was brought to his attention, the information reported to him did not indicate the CNA had been rough, and the incident was nothing close to rough treatment. The DON also indicated to the family member, "Yes, if someone was rough, you should have been told, but I don't know if it is true." The DON and Administrator indicated no investigation had been conducted because no rough treatment had occurred.</p> <p>During interview on 12/12/11 at 9:30 p.m., CNA #1 indicated she was not aware of any resident being abused.</p> <p>During interview on 12/12/11 at 9:40 p.m., CNA #2 indicated CNA #1 was grouchy toward residents and treats them "crappy." She also indicated she was in the room with CNA #1 when she was taking care of Resident #A and CNA #1 was in a hurry and grabbed Resident #A's legs and pulled them apart. CNA #2 stated, "I know it hurt her because she acted like she was going to cry." CNA #2 indicated she confronted CNA #1 about being rough with Resident #A and CNA #1 stated, "We have to get our job done." CNA #2 indicated before she talked to the</p>		<p>education and monitoring. In addition to reporting to the ISDH, APS and the Ombudsman were notified of this occurrence and any further allegations. Corrective action will be QA monitored using the Administrative Services Review-Nursing Services and Resident Interviews Abuse Prohibition Tool. All interviewable residents will be interviewed by DON, Social Services, Administrator or designee using the Resident Questionnaire Tool to assess for any allegations of abuse daily x 7 days, then weekly x 4 weeks, then monthly x 6 months. This process will be monitored using the Quality improvement tool-Administrative Services Review-Nursing Services and Residnet Interviews Abuse Prohibition Tool. The results will be reviewed by the Quality Assurance Committee and any recommendations made will be implemented.</p>		

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	<p>DON, she talked to the Assistant Director of Nursing (ADON), and staff RN #3 and then she told the DON about the incident, and the DON didn't do anything about it, so she reported it to the Administrator.</p> <p>During interview on 12/12/11 at 10:15 p.m., the ADON stated, "I was present when (CNA #2) talked to the DON and she talked to her two times. The first discussion (CNA #2) was worried about (CNA #1) taking care of (Resident #A), she felt she was rough but didn't believe she did it intentionally. She just seemed to be in a hurry to get things done. The second time she talked to the DON, I believe it was the next day, and told the DON that she had thought about it and does believe (CNA #1) had done it intentionally. The DON asked her why she didn't tell her that the first time and the DON was concerned because (CNA #2's) story had changed."</p> <p>During interview on 12/13/11 at 11:45 a.m., Staff RN #3, indicated she thought it was the 29th or 30th of November when CNA #2 felt that CNA #1 was being rough with one of the residents, Resident #A. She also indicated she instructed CNA #2 to go speak with the DON immediately, and staff RN #3, stated, "I didn't ask any questions just told her to go tell the DON. I am not sure why (CNA</p>				

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	<p>#2) approached me about the situation." Staff RN #3 indicated that she did not do an investigation or follow up on the situation but she did talk with the DON the same day that CNA #2 reported the allegation, and she told the DON what CNA #2 told her. Staff RN #3 indicated she followed up with the DON about CNA #2's concern and the DON was aware of the situation and that CNA #2 had talked to her. Staff RN #3 also indicated she was responsible for scheduling. Staff RN #3 indicated CNA #1 worked the following evenings 2nd shift on the east wing since the allegation of rough treatment:</p> <ul style="list-style-type: none"> <li>- 11/29/11</li> <li>- 11/30/11</li> <li>- 12/3/11</li> <li>- 12/4/11</li> <li>- 12/5/11</li> <li>- 12/6/11</li> <li>- 12/7/11</li> <li>- 12/10/11</li> <li>- 12/11/11</li> <li>- 12/12/11</li> </ul> <p>Staff RN #3 indicated CNA #1 is off the schedule as of 12/13/11, until the Administration feels she can come back to work.</p> <p>A document provided by the DON on 12/12/11 at 10:30 p.m., dated 11/30/11, and signed by the DON and ADON</p>				

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	indicated the following: "(Staff RN #3), informed me that (CNA #2) has reported to her that she had concerns with another CNA, (CNA #1) regarding her attitude and felt she was a little 'grumpy' with a couple of the residents. I requested to see (CNA #2) to discuss this concern she had voiced....(CNA #2) also stated that she felt (CNA #1) should have talked to (Resident #A) about relaxing in order to assist in changing (Resident #A) but instead pulled her legs apart without telling (Resident #A) what she was doing to her. (CNA #2) stated that (Resident #A) 'made a face' like she was uncomfortable when (CNA #1) was changing her....(The Administrator) came to my office to ask if I was aware of a concern that (CNA #2) had with (CNA #1). I informed him that I was and asked why (CNA #2) had come to him. (The Administrator) stated that (CNA #2) had mentioned the word 'abuse' and asked what she should do if she thought someone abused a resident. (The administrator stated to report it and he would inform me of her concerns.) I informed (Administrator) that in no way had her concerns the day prior been indicative of any type of abuse at all. I informed him her concerns were only that (CNA #1) was acting 'different' and seemed kind of grumpy. I informed (Administrator) I would address the				

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	<p>situation with (CNA #2) as her allegations are not consistent with what she discussed with me the day prior.</p> <p>I spoke with (CNA #2) regarding our conversation the day prior and what she had told (Administrator) was nothing like she had spoken with me about. I asked her why she had used the word abuse when I had specifically asked her yesterday if she felt (CNA #1) intended to harm the residents and her response was 'no.' I had asked if she felt that (CNA #1) was aware that she may have made (Resident #A) uncomfortable when she was changing her and she said 'no.' (CNA #2) stated the reason that she was asking questions about abuse was because she went home and had 'time to think' about what had happened and thought maybe it could be seen as abuse. I asked her what made her think so now as if it truly was an abusive act it should have been apparent at the time it occurred. (CNA #2) stated that when (CNA #1) was changing (Resident #A) she pulled her legs apart and said 'God (Resident #A)' and pulled her legs apart. I informed (CNA #2) that she made no mention of this occurring the day prior and was even asked specifically if she thought (CNA #1) meant (Resident #A) harm and her response was 'no.' I informed (CNA #2) that abuse is a severe allegation and must be reported immediately and should not be an after</p>				

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	<p>thought. (CNA #2) stated that she went home and thought about the situation and wasn't accusing (CNA #1) of abuse, but wondered what to do if she suspected abuse and who she should report it to. I informed (CNA #2) that she had discussed her concerns with several people (Staff RN #3), myself and (Administrator) and that she should be well aware of whom to report suspected abuse to. I reminded (CNA #2) of her orientation on education on abuse reporting as well as the many in-services that have been held that covered abuse and reporting of abuse. (CNA #2) again denied believing that (CNA #1) meant harm but that she was 'different' acting. I instructed (CNA #2) to report any suspected abuse immediately but be cautious when using the word abuse out of context as staff members being accused could not only lose their jobs but their license as well. (CNA #2) voiced understanding."</p> <p>A document titled Rushville Miller's Merry Manor Floor Schedule-all units/all shifts indicated CNA #1 worked 2nd shift the following days:</p> <ul style="list-style-type: none"> <li>- 11/29/11</li> <li>- 11/30/11</li> <li>- 12/3/11</li> <li>- 12/4/11</li> <li>- 12/5/11</li> </ul>				

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	<p>- 12/6/11 - 12/7/11 - 12/10/11 - 12/11/11 - 12/12/11</p> <p>The Miller's Merry Manor Floor Schedule, indicated CNA #2 worked 10 days after the report of rough treatment.</p> <p>During an interview on 12/15/11 at 12:45 p.m., the DON indicated a full body assessment was not completed on 11/30/11 but a full body assessment was completed on 12/13/11 at 12:17 a.m.</p> <p>A document titled "Abuse Prohibition, Reporting and Investigation" provided by the DON on 12/12/11 at 8:15 p.m., dated 8/23/11, indicated by the DON to be the most current policy, indicated the following: Investigation and Reporting to Correct Authority, The facility administrator is designated as the individual responsible for coordinating all efforts in investigation of abuse allegations, and for assuring that all policies and procedures are followed. In his/her absence, this responsibility is delegated to the Director of Nursing Services. All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative (sponsor, responsible</p>				

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	<p>party), as soon as feasibly possible, but no later than within 24 hours of the reporting or discovery of the incident. The administrator, or designee, shall initiate and direct the investigation immediately, and within 5 days a report of the investigation must be reported to the Long Term Care Division of the Indiana State Department of Health.</p> <p>Resident Abuse Procedure, The resident(s) involved in the incident will be removed from the situation at once. The individual who witnessed the incident will immediately report the situation to the nurse in charge. If this is not possible, the individual will report the situation to any nurse on duty. Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until the investigation is completed. A thorough investigation will be initiated and employee conduct policies implemented as appropriate. An investigation will be completed to assure other residents have not been affected by the incident or inappropriate behavior and the results documented. This may involve interviewing staff members when appropriate. The investigation summary compiled by the Administrator or designee may include, but is not limited to: facts and observation from the involved resident or residents, facts and observations from the involved employee</p>				

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	<p>or employees, facts and observations from witnessing employees or those that intervened in the incident, facts and observations from visitors or others who might have pertinent information that is relevant to the investigation, facts and observations by the charge nurse or individual whom the initial allegation of abuse was made, injuries or lack thereof based upon the nursing assessment following the incident and timelines. The summary of the investigation will be signed and dated by the Administrator or designee and will be kept by the facility.</p> <p>This federal tag relates to Complaint IN00100626.</p> <p>3.1-28(a)</p>				

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F0225 SS=E	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview and record review, the facility failed to thoroughly and immediately investigate an allegation of rough treatment at the time the rough treatment was reported and</p>	F0225	Resident #A was fully assessed and no evidence of injury or distress was noted. Resident #A's Physician was updated and the care plan was updated to indicate that prior to providing	01/10/2012	

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	<p>failed to protect the resident from further potential of rough treatment for 1 of 6 residents sampled for rough treatment in a total sample of 5 and supplemental sample of 3 (Resident #A) This had the potential to affect 35 of 35 residents residing on the east wing of the facility where the alleged perpetrator worked. The alleged perpetrator was allowed to provide resident care for ten shifts after the allegation was reported. The facility also failed to report the allegation of rough treatment to the Indiana State Department of Health.</p> <p>Findings include:</p> <p>The record of Resident #A was reviewed on 12/13/11 at 10:00 a.m. The record indicated Resident #A's diagnoses included, but were not limited to, anoxic (deficiency of oxygen) brain damage, closed dislocation first cervical vertebra and quadriplegia.</p> <p>Resident #A's Minimum Data Set (MDS) dated 10/26/11 indicated the following:</p> <ul style="list-style-type: none"> <li>- speech clarity, no speech</li> <li>- makes self understood, rarely/never understood</li> <li>- ability to understand others, rarely/never understands</li> <li>- brief interview for mental status, resident was unable to complete the</li> </ul>		<p>Resident #A care, staff should explain what they are doing and encourage the resident to relax and approach her slowly, especially with peri care. Social Services attempted to communicate with Resident #A to assess for any signs of distress-no evidence of distress, negative outcome or changes in Resident #A were noted. CNA #1 was placed on suspension pending an investigation. All 36 residents on East wing and all 35 residents on West wing were either directly questioned or physically observed for signs of distress by Administrative/ Nursing staff to assess for concerns regarding rough treatment by staff. All nursing staff on duty were also interviewed to determine if they were aware of any resident mistreatment. All staff on duty from initial allegation received on 12.12.11, including department heads and Therapy, have been re-educated on the Abuse Prohibition Policy and Procedure, definitions of abuse and process for reporting abuse and/ or allegations of abuse. All remaining staff have been re-educated on the Abuse Prohibition Policy and Procedure, definitions of abuse and process for reporting abuse and/ or allegations of abuse on 12.22.11. The Vice President of Quality Assurance and Regional Quality Assurance Nurse have been</p>		

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	<p>interview</p> <ul style="list-style-type: none"> <li>- transfer, total dependence</li> <li>- walk in room or corridor, activity did not occur</li> <li>- dressing, total dependence</li> <li>- incontinent of bladder and bowels</li> </ul> <p>Resident #A was observed on 12/12/11 at 8:00 p.m., in bed on left side, with gastric-tube feeding infusing, tracheotomy in place, eyes open, and unable to speak</p> <p>On 12/12/11 at 8:45 p.m., a family member of Resident #A requested a meeting that would also include the DON and Administrator. During the meeting, the family member indicated it was reported to him by an anonymous employee at the facility on 11/28/11, that a CNA grabbed Resident #A's legs open in a rough manner. The family member indicated the rough treatment was reported to the DON by the staff and Resident #A had a chunk out of her leg, multiple bruises and a scratch on her face the day it happened. The family member stated, "I felt I should have been notified of the rough treatment, but I was not notified of the rough treatment." The Administrator indicated at the time the incident was brought to his attention, the information reported to him did not indicate the CNA had been rough, and the incident was nothing close to rough</p>		<p>informed of the allegations of abuse and the concerns reported from the ISDH, a CNA and Resident A's family member. The Administrator and DON have been re-educated on their role in the Abuse Prohibition Policy and these roles have been clearly defined and reviewed and will be monitored to assure compliance has been maintained. Medical Director Dr. Richard Boersma, MD was informed of the previously listed allegations and concurs with the plan of education and monitoring. In addition to reporting to the ISDH, APS and the Ombudsman were notified of this occurrence and any further allegations. Corrective action will be QA monitored using the Administrative Services Review-Nursing Services and Resident Interviews Abuse Prohibition Tool. All interviewable residents will be interviewed by DON, Social Services, Administrator or designee using the Resident Questionnaire Tool to assess for any allegations of abuse daily x 7 days, then weekly x 4 weeks, then monthly x 6 months. This process will be monitored using the Quality improvement tool-Administrative Services Review-Nursing Services and Residnet Interviews Abuse Prohibition Tool. The results will be reviewed by the Quality Assurance Committee and any recommendtations made will be</p>		

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	<p>treatment. The DON also indicated to the family member, "Yes, if someone was rough, you should have been told, but I don't know if it is true." The DON and Administrator indicated no investigation had been conducted because no rough treatment had occurred.</p> <p>During interview on 12/12/11 at 9:30 p.m., CNA #1 indicated she was not aware of any resident being abused.</p> <p>During interview on 12/12/11 at 9:40 p.m., CNA #2 indicated CNA #1 was grouchy toward residents and treats them "crappy." She also indicated she was in the room with CNA #1 when she was taking care of Resident #A and CNA #1 was in a hurry and grabbed Resident #A's legs and pulled them apart. CNA #2 stated, "I know it hurt her because she acted like she was going to cry." CNA #2 indicated she confronted CNA #1 about being rough with Resident #A and CNA #1 stated, "We have to get our job done." CNA #2 indicated before she talked to the DON, she talked to the Assistant Director of Nursing (ADON), and staff RN #3 and then she told the DON about the incident, and the DON didn't do anything about it, so she reported it to the Administrator.</p> <p>During interview on 12/12/11 at 10:15 p.m., the ADON stated, "I was present</p>		implemented. Date of compliance-		

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	<p>when (CNA #2) talked to the DON and she talked to her two times. The first discussion (CNA #2) was worried about (CNA #1) taking care of (Resident #A) she felt she was rough but didn't believe she did it intentionally. She just seemed to be in a hurry to get things done. The second time she talked to the DON, I believe it was the next day and told the DON that she had thought about it and does believe (CNA #1) had done it intentionally. The DON asked her why she didn't tell her that the first time and the DON was concerned because (CNA #2's) story had changed."</p> <p>During interview on 12/13/11 at 11:45 a.m., Staff RN #3, indicated she thought it was the 29th or 30th of November when CNA #2 felt that CNA #1 was being rough with one of the residents, Resident #A. She also indicated she instructed CNA #2 to go speak with the DON immediately and staff RN #3, stated, "I didn't ask any questions just told her to go tell the DON. I am not sure why (CNA #2) approached me about the situation." Staff RN #3 indicated that she did not do an investigation or follow up on the situation but she did talk with the DON the same day that CNA #2 reported the allegation, and she told the DON what CNA #2 told her. Staff RN #3 indicated she followed up with the DON about</p>				

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	<p>CNA #2's concern and the DON was aware of the situation and that CNA #2 had talked to her. Staff RN #3 also indicated she was responsible for scheduling. Staff RN #3 indicated CNA #1 worked the following evenings 2nd shift on the east wing since the allegation of rough treatment:</p> <ul style="list-style-type: none"> <li>- 11/29/11</li> <li>- 11/30/11</li> <li>- 12/3/11</li> <li>- 12/4/11</li> <li>- 12/5/11</li> <li>- 12/6/11</li> <li>- 12/7/11</li> <li>- 12/10/11</li> <li>- 12/11/11</li> <li>- 12/12/11</li> </ul> <p>Staff RN #3 indicated CNA #1 is off the schedule as of 12/13/11, until the Administration feels she can come back to work.</p> <p>A document provided by the DON on 12/12/11 at 10:30 p.m., dated 11/30/11, and signed by the DON and ADON indicated the following: "(Staff RN #3), informed me that (CNA #2) has reported to her that she had concerns with another CNA, (CNA #1) regarding her attitude and felt she was a little 'grumpy' with a couple of the residents. I requested to see (CNA #2) to discuss this concern she had voiced...(CNA #2) also stated that she</p>				

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	<p>felt (CNA #1) should have talked to (Resident #A) about relaxing in order to assist in changing (Resident #A) but instead pulled her legs apart without telling (Resident #A) what she was doing to her. (CNA #2) stated that (Resident #A) 'made a face' like she was uncomfortable when (CNA #1) was changing her....(The Administrator) came to my office to ask if I was aware of a concern that (CNA #2) had with (CNA #1). I informed him that I was and asked why (CNA #2) had come to him. (The Administrator) stated that (CNA #2) had mentioned the word 'abuse' and asked what she should do if she thought someone abused a resident. (The administrator stated to report it and he would inform me of her concerns.) I informed (Administrator) that in no way had her concerns the day prior been indicative of any type of abuse at all. I informed him her concerns were only that (CNA #1) was acting 'different' and seemed kind of grumpy. I informed (Administrator) I would address the situation with (CNA #2) as her allegations are not consistent with what she discussed with me the day prior.</p> <p>I spoke with (CNA #2) regarding our conversation the day prior and what she had told (Administrator) was nothing like she had spoken with me about. I asked her why she had used the word abuse</p>				

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	<p>when I had specifically asked her yesterday if she felt (CNA #1) intended to harm the residents and her response was 'no.' I had asked if she felt that (CNA #1) was aware that she may have made (Resident #A) uncomfortable when she was changing her and she said 'no.' (CNA #2) stated the reason that she was asking questions about abuse was because she went home and had 'time to think' about what had happened and thought maybe it could be seen as abuse. I asked her what made her think so now as if it truly was an abusive act it should have been apparent at the time it occurred. (CNA #2) stated that when (CNA #1) was changing (Resident #A) she pulled her legs apart and said 'God (Resident #A)' and pulled her legs apart. I informed (CNA #2) that she made no mention of this occurring the day prior and was even asked specifically if she thought (CNA #1) meant (Resident #A) harm and her response was 'no.' I informed (CNA #2) that abuse is a severe allegation and must be reported immediately and should not be an after thought. (CNA #2) stated that she went home and thought about the situation and wasn't accusing (CNA #1) of abuse, but wondered what to do if she suspected abuse and who she should report it to. I informed (CNA #2) that she had discussed her concerns with several people (Staff RN #3), myself and</p>			

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	<p>(Administrator) and that she should be well aware of whom to report suspected abuse to. I reminded (CNA #2) of her orientation on education on abuse reporting as well as the many in-services that have been held that covered abuse and reporting of abuse. (CNA #2) again denied believing that (CNA #1) meant harm but that she was 'different' acting. I instructed (CNA #2) to report any suspected abuse immediately but be cautious when using the word abuse out of context as staff members being accused could not only lose their jobs but their license as well. (CNA #2) voiced understanding."</p> <p>A document titled Rushville Miller's Merry Manor Floor Schedule-all units/all shifts indicated CNA #1 worked 2nd shift the following days:</p> <ul style="list-style-type: none"> <li>- 11/29/11</li> <li>- 11/30/11</li> <li>- 12/3/11</li> <li>- 12/4/11</li> <li>- 12/5/11</li> <li>- 12/6/11</li> <li>- 12/7/11</li> <li>- 12/10/11</li> <li>- 12/11/11</li> <li>- 12/12/11</li> </ul> <p>The Miller's Merry Manor Floor Schedule, indicated CNA #2 worked 10 days after the report of rough treatment.</p>				

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	<p>During an interview on 12/15/11 at 12:45 p.m., the DON indicated a full body assessment was not completed on 11/30/11 but a full body assessment was completed on 12/13/11 at 12:17 a.m.</p> <p>A document titled "Abuse Prohibition, Reporting and Investigation" provided by the DON on 12/12/11 at 8:15 p.m., dated 8/23/11, indicated by the DON to be the most current policy, indicated the following:</p> <p>Investigation and Reporting to Correct Authority, The facility administrator is designated as the individual responsible for coordinating all efforts in investigation of abuse allegations, and for assuring that all policies and procedures are followed. In his/her absence, this responsibility is delegated to the Director of Nursing Services. All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative (sponsor, responsible party), as soon as feasibly possible, but no later than within 24 hours of the reporting or discovery of the incident. The administrator, or designee, shall initiate and direct the investigation immediately, and within 5 days a report of the investigation must be reported to the Long Term Care Division of the Indiana State</p>				

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	<p>Department of Health. Resident Abuse Procedure, The resident(s) involved in the incident will be removed from the situation at once. The individual who witnessed the incident will immediately report the situation to the nurse in charge. If this is not possible, the individual will report the situation to any nurse on duty. Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until the investigation is completed. A thorough investigation will be initiated and employee conduct policies implemented as appropriate. An investigation will be completed to assure other residents have not been affected by the incident or inappropriate behavior and the results documented. This may involve interviewing staff members when appropriate. The investigation summary compiled by the Administrator or designee may include, but is not limited to: facts and observation from the involved resident or residents, facts and observations from the involved employee or employees, facts and observations from witnessing employees or those that intervened in the incident, facts and observations from visitors or others who might have pertinent information that is relevant to the investigation, facts and observations by the charge nurse or individual whom the initial allegation of</p>				

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F0226 SS=E	<p>abuse was made, injuries or lack thereof based upon the nursing assessment following the incident and timelines. The summary of the investigation will be signed and dated by the Administrator or designee and will be kept by the facility.</p> <p>This federal tag relates to Complaint IN00100626.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview and record review, the facility failed to implement policy for reporting, investigating, and protecting residents related to allegations of rough treatment for 1 of 6 residents reviewed related to allegations of rough treatment in a sample of 5 and supplemental sample of 3. This deficient practice had the potential to affect 35 of 35 residents on the east wing of the facility. (Resident #A)</p>	F0226	Resident #A was fully assessed and no evidence of injury or distress was noted. Resident #A's Physician was updated and the care plan was updated to indicate that prior to providing Resident #A care, staff should explain what they are doing and encourage the resident to relax and approach her slowly, especially with peri care. Social Services attempted to communicate with Resident #A to assess for any signs of distress-no evidence of distress,	01/10/2012	

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	<p>Findings include:</p> <p>A document titled "Abuse Prohibition, Reporting and Investigation" provided by the DON on 12/12/11 at 8:15 p.m., dated 8/23/11, indicated by the DON to be the most current policy, indicated the following:</p> <p>Investigation and Reporting to Correct Authority, The facility administrator is designated as the individual responsible for coordinating all efforts in investigation of abuse allegations, and for assuring that all policies and procedures are followed. In his/her absence, this responsibility is delegated to the Director of Nursing Services. All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative (sponsor, responsible party), as soon as feasibly possible, but no later than within 24 hours of the reporting or discovery of the incident. The administrator, or designee, shall initiate and direct the investigation immediately, and within 5 days as report of the investigation must be reported to the Long Term Care Division of the Indiana State Department of Health.</p> <p>Resident Abuse Procedure, The resident(s) involved in the incident will be removed from the situation at once. The individual who witnessed the incident will</p>		<p>negative outcome or changes in Resident #A were noted. CNA #1 was placed on suspension pending an investigation. All 36 residents on East wing and all 35 residents on West wing were either directly questioned or physically observed for signs of distress by Administrative/ Nursing staff to assess for concerns regarding rough treatment by staff. All nursing staff on duty were also interviewed to determine if they were aware of any resident mistreatment. All staff on duty from initial allegation received on 12.12.11, including department heads and Therapy, have been re-educated on the Abuse Prohibition Policy and Procedure, definitions of abuse and process for reporting abuse and/ or allegations of abuse. All remaining staff have been re-educated on the Abuse Prohibition Policy and Procedure, definitions of abuse and process for reporting abuse and/ or allegations of abuse on 12.22.11. The Vice President of Quality Assurance and Regional Quality Assurance Nurse have been informed of the allegations of abuse and the concerns reported from the ISDH, a CNA and Resident A's family member. The Administrator and DON have been re-educated on their role in the Abuse Prohibition Policy and these roles have been clearly defined and reviewed and will be</p>		

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	immediately report the situation to the nurse in charge. If this is not possible, the individual will report the situation to any nurse on duty. Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until the investigation is completed. A thorough investigation will be initiated and employee conduct policies implemented as appropriate. An investigation will be completed to assure other residents have not been affected by the incident or inappropriate behavior and the results documented. This may involve interviewing staff members when appropriate. The investigation summary compiled by the Administrator or designee may include, but is not limited to: facts and observation from the involved resident or residents, facts and observations from the involved employee or employees, facts and observations from witnessing employees or those that intervened in the incident, facts and observations from visitors or others who might have pertinent information that is relevant to the investigation, facts and observations by the charge nurse or individual whom the initial allegation of abuse was made, injuries or lack thereof based upon the nursing assessment following the incident and timelines. The summary of the investigation will be signed and dated by the Administrator or		monitored to assure compliance has been maintained. Medical Director Dr. Richard Boersma, MD was informed of the previously listed allegations and concurs with the plan of education and monitoring. In addition to reporting to the ISDH, APS and the Ombudsman were notified of this occurrence and any further allegations. Corrective action will be QA monitored using the Administrative Services Review-Nursing Services and Resident Interviews Abuse Prohibition Tool. All interviewable residents will be interviewed by DON, Social Services, Administrator or designee using the Resident Questionnaire Tool to assess for any allegations of abuse daily x 7 days, then weekly x 4 weeks, then monthly x 6 months. This process will be monitored using the Quality improvement tool-Administrative Services Review-Nursing Services and Residnet Interviews Abuse Prohibition Tool. The results will be reviewed by the Quality Assurance Committee and any recommendtdations made will be implemented.		

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	<p>designee and will be kept by the facility.</p> <p>The record of Resident #A was reviewed on 12/13/11 at 10:00 a.m. The record indicated Resident #A's diagnoses included, but were not limited to, anoxic (deficiency of oxygen) brain damage, closed dislocation first cervical vertebra and quadriplegia.</p> <p>Resident #A's Minimum Data Set (MDS) dated 10/26/11 indicated the following:</p> <ul style="list-style-type: none"> <li>- speech clarity, no speech</li> <li>- makes self understood, rarely/never understood</li> <li>- ability to understand others, rarely/never understands</li> <li>- brief interview for mental status, resident was unable to complete the interview</li> <li>- transfer, total dependence</li> <li>- walk in room or corridor, activity did not occur</li> <li>- dressing, total dependence</li> <li>- incontinent of bladder and bowels</li> </ul> <p>Resident #A was observed on 12/12/11 at 8:00 p.m., in bed on left side, with gastric-tube feeding infusing, tracheotomy in place, eyes open, and unable to speak</p> <p>A family member requested a meeting with the surveyor, DON and Administrator on 12/12/11 at 8:45 p.m.,</p>				

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	<p>and during the meeting the family member indicated it was reported to him by an anonymous employee at the facility on 11/28/11, a CNA grabbed Resident #A's legs open in a rough manner. The family member indicated the rough treatment was reported to the DON by the staff and Resident #A had a chunk out of her leg, multiple bruises and a scratch on her face the day it happened. The family member stated "I felt I should have been notified of the rough treatment but I was not notified of the rough treatment." The Administrator indicated at the time the incident was brought to his attention the information reported to him it did not indicate the CNA had treated the resident rough and the incident was nothing close to rough treatment. The DON also indicated to the family member, "yes, if someone was rough, you should have been told, but I don't know if it is true." The DON and Administrator indicated no investigation had been conducted because no rough treatment had occurred.</p> <p>During interview with CNA #1 on 12/12/11 at 9:30 p.m., indicated she was not aware of any resident being abused.</p> <p>During interview with CNA #2 on 12/12/11 at 9:40 p.m., indicated CNA #1 was grouchy toward residents and treats them "crappy." She also indicated she</p>						

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	<p>was in the room with CNA #1 when she was taking care of Resident #A and CNA #1 was in a hurry and grabbed Resident #A's legs and pulled them apart and she stated "I know it hurt her because she acted like she was going to cry." CNA #2 indicated she confronted CNA #1 about being rough with Resident #A and CNA #1 stated "we have to get our job done." CNA #2 indicated before she talked to the DON she talked to the Assistant Director of Nursing (ADON) and staff RN #3 and then she told the DON about the incident and the DON didn't do anything about it so she reported it to the Administrator.</p> <p>During interview on 12/12/11 at 10:15 p.m., the ADON stated "I was present when (CNA #2) talked to the DON and she talked to her two times. The first discussion (CNA #2) was worried about (CNA #1) taking care of (Resident #A) she felt she was rough but didn't believe she did it intentionally. She just seemed to be in a hurry to get things done. The second time she talked to the DON, I believe it was the next day and told the DON that she had thought about it and does believe (CNA #1) had done it intentionally. The DON ask her why she didn't tell her that the first time and the DON was concerned because (CNA #2's) story had changed."</p>				

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	<p>During interview on 12/13/11 at 11:45 a.m., Staff RN #3, indicated she thought it was the 29th or 30th of November CNA #2 felt that CNA #1 was being rough with one of the residents, Resident #A. She also indicated she instructed CNA #2 to go speak with the DON immediately and staff RN #3, stated "I didn't ask any questions just told her to go tell the DON. I am not sure why (CNA #2) approached me about the situation." Staff RN #3 indicated that she did not do an investigation or follow up on the situation but she did talk with the DON the same day that CNA #2 reported the allegation and I told the DON what CNA #2 told me. Staff RN #3 indicated she followed up with the DON about CNA #2's concern and the DON was aware of the situation and that CNA #2 had talked to her. Staff RN #3 also indicated she was responsible for scheduling. Staff RN #3 indicated CNA #1 worked the following evenings 2nd shift on the east wing since the allegation of rough treatment:</p> <ul style="list-style-type: none"> <li>- 11/29/11</li> <li>- 11/30/11</li> <li>- 12/3/11</li> <li>- 12/4/11</li> <li>- 12/5/11</li> <li>- 12/6/11</li> <li>- 12/7/11</li> <li>- 12/10/11</li> <li>- 12/11/11</li> </ul>				

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	<p>- 12/12/11</p> <p>Staff RN #3 indicated CNA #1 is off the schedule as of 12/13/11, until the Administration feels she can come back to work.</p> <p>A document provided by the DON on 12/12/11 at 10:30 p.m., dated, 11/30/11, and signed by the DON and ADON indicated the following: "(Staff RN #3), informed me that (CNA #2) has reported to her that she had concerns with another CNA, (CNA #1) regarding her attitude and felt she was a little 'grumpy' with a couple of the residents. I requested to see (CNA #2) to discuss this concerns she had voiced...(CNA #2) also stated that she felt (CNA #1) should have talked to (Resident #A) about relaxing in order to assist in changing (Resident #A) but instead pulled her legs apart without telling (Resident #A) what she was doing to her. (CNA #2) stated that (Resident #A) 'made a face' like she was uncomfortable when (CNA #1) was changing her...(The Administrator) came to my office to ask if I was aware of a concern that (CNA #2) had with (CNA #1). I informed him that I was and asked why (CNA #2) had come to him. (The Administrator) stated that (CNA #2) had mentioned the word 'abuse' and asked what she should do if she thought someone abused a resident. (The</p>				

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	<p>administrator stated to report it and he would inform me of her concerns. I informed (Administrator) that in no way had her concerns the day prior been indicative of any type of abuse at all. I informed him her concerns were only that (CNA #1) was acting 'different' and seemed kind of grumpy. I informed (Administrator) I would address the situation with (CNA #2) as her allegations are not consistent with what she discussed with me the day prior.</p> <p>I spoke with (CNA #2) regarding our conversation the day prior and what she had told (Administrator) was nothing like she had spoken with me about. I asked her why she had used the word abuse when I had specifically asked her yesterday if she felt (CNA #1) intended to harm the residents and her response was 'no.' I had asked if she felt that (CNA #1) was aware that she may have made (Resident #A) uncomfortable when she was changing her and she said 'no.' (CNA #2) stated the reason that she was asking questions about abuse was because she went home and had 'time to think' about what had happened and thought maybe it could be seen as abuse. I asked her what made her think so now as if it truly was an abusive act it should have been apparent at the time it occurred. (CNA #2) stated that when (CNA #1) was changing (Resident #A) she pulled her legs apart</p>			

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	and said 'God (Resident #A)' and pulled her legs apart. I informed (CNA #2) that she made no mention of this occurring the day prior and was even asked specifically if she thought (CNA #1) meant (Resident #A) harm and her response was 'no.' I informed (CNA #2) that abuse is a severe allegation and must be reported immediately and should not be an after thought. (CNA #2) stated that she went home and thought about the situation and wasn ' t accusing (CNA #1) of abuse, but wondered what to do if she suspected abuse and who she should report it to. I informed (CNA #2) that she had discussed her concerns with several people (Staff RN #3), myself and (Administrator) and that she should be well aware of whom to report suspected abuse to. I reminded (CNA #2) of her orientation on education on abuse reporting as well as the many in-services that have been held that covered abuse and reporting of abuse. (CNA #2) again denied believing that (CNA #1) meant harm but that she was 'different' acting. I instructed (CNA #2) to report any suspected abuse immediately but be cautious when using the word abuse out of context as staff members being accused could not only lost their jobs but their license as well. (CNA #2) voiced understanding."				

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	<p>A document titled Rushville Miller's Merry Manor Floor Schedule-all units/all shifts indicated CNA #1 worked 2nd shift the following days:</p> <ul style="list-style-type: none"> <li>- 11/29/11</li> <li>- 11/30/11</li> <li>- 12/3/11</li> <li>- 12/4/11</li> <li>- 12/5/11</li> <li>- 12/6/11</li> <li>- 12/7/11</li> <li>- 12/10/11</li> <li>- 12/11/11</li> <li>- 12/12/11</li> </ul> <p>The Miller's Merry Manor Floor Schedule, indicated CNA #2 worked 10 days after the report of rough treatment.</p> <p>3.1-28(a)</p>				

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F0328 SS=D	<p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on interview and record review, the facility failed to keep a tracheotomy tube (opening in the neck through the trachea to provide and airway) at the bedside of one resident with an existing tracheotomy tube in place for 1 of 1 resident reviewed for tracheotomy tubes in place in a sample of 5. (Resident #A)</p> <p>Findings include:</p> <p>The record of Resident #A was reviewed on 12/13/11 at 10:00 a.m. The record indicated Resident #A's diagnoses included, but were not limited to, anoxic (deficiency of oxygen) brain damage, closed dislocation first cervical vertebra and quadriplegia.</p> <p>Resident #A's physician recapitulation orders dated 12/11, indicated "change trach every month and as needed, #4 cuffless Shiley with inner cannula (monthly on the 7th).</p>	F0328	<p>A tracheostomy tube was located and placed at Resident #A's bedside during the survey. A tracheostomy tube of the same size and one of a size smaller has been placed at bedside of Resident #A with a sign indicating "Spare trach located inside drawer" placed on the outside of the drawer. Nursing staff informed of location of spare tracheostomy tubes.No other residents have been affected by this deficiency as no other residents currently have tracheostomy tubes.Nursing staff inservice held on 12.22.11 to re-educate staff on the Policy and Procedure for Tracheostomy Tubes and the importance of having a backup tracheostomy tube of the same size and one the next size smaller at bedside. Corrective action will be QA monitored using the Tracheostomy Tube audit tool. This QA tool will be used by the DON or designee daily x 1 week, weekly x 4 weeks, then monthly x 6 months to ensure a spare trach of the current size and one a size</p>	01/10/2012	

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	<p>During interview on 12/13/11 at 3:00 p.m., the Unit Manager #5 indicated the facility did not have an emergency tracheotomy tube at the bedside. Unit Manager #5 stated, "We only had one tracheotomy tube and when (Resident #A) was sent to the hospital about 2 weeks ago they took the emergency tracheotomy tube to the hospital and did not bring it back, but we do have a tracheotomy tube on order."</p> <p>Lippincott Manual of Nursing Practice, 8th edition, "Procedure Guidelines, assisting with tracheotomy, an extra tube...should be kept at the bedside. In the event of tube dislodgement, reinsertion of a new tube may be necessary. For emergency tube insertion."</p> <p>A document titled "Tracheotomy Tubes" provided by the DON on 12/14/11 at 2:50 p.m., dated 1/28/11, to be the most current policy, indicated the following: "Policy, Every tracheotomy patient must have a backup trach tube of the same size and one the next size smaller."</p> <p>3.1-47(a)(4)</p>		<p>smaller is located at the bedside of all residents with a tracheostomy tube; and to ensure staff awareness of the location of the spare tracheostomy tubes. This process will be monitored using the Quality Improvement tool- Tracheostomy Tube Review. The results will be reviewed by the Quality Assurance Committee and any recommendations made will be implemented.</p>		

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F0332 SS=D	<p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% for 3 of 3 residents observed receiving medications from a supplemental sample of 3 (Residents #C, #H, and #I). Eight errors in medication administration were observed during 78 opportunities for error in medication administration. This resulted in a medication error rate of 10.2%.</p> <p>Findings include:</p> <p>1. During medication pass observation on 12-12-11 at 8:34 p.m., LPN #4 prepared Zantac 150 milligrams (mg), Armour thyroid 60 mg, colace 200 mg, Tramadol HCL 50 mg and Temazepam 15 mg and administered the medication to Resident #C.</p> <p>Interview with LPN #4 on 12-13-11 at 2:42 p.m., indicated she overlooked giving Aspirin to Resident #C. LPN #4</p>	F0332	<p>A Medication error report was completed for the omitted dose of Aspirin for Resident #C. Medication error reports were completed for Resident #C, #H, #I regarding the untimely administration of medications. Resident #C, #H and #I assessed with no adverse effects noted. LPN #4 re-educated on the 5 rights of a medication pass and on the Medication Administration Procedure-specific to the policy of "ensure that the resident receives the med at the correct time-60 minutes before or after the scheduled time".All residents have the potential to be affected by this deficiency. No other residents were found to be affected by this deficient practice. Education and audits will be completed as stated below.Nursing staff inservice held 12.22.22 to re-educate staff on the Medication Administration Procedure to ensure the awareness of the 5 rights of a medication pass and to ensure the awareness that medications must be passed either 60 minutes</p>	01/10/2012	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated she must have overlooked the Aspirin on Resident #C's Medication Administration Record (MAR).</p> <p>Review of the clinical record on 12-14-11 at 10:40 a.m., the physician recapitulation (recap) dated December 2011 for Resident #C indicated the resident was ordered Bayer Aspirin 81 mg daily by mouth at 8:00 p.m.</p> <p>2. During medication pass observation on 12-12-11 at 9:30 p.m., LPN #4 prepared and administered Hydrocodone (pain medication) 7.5/500 mg, Reglan 5 mg, Oxcarbazepine 150 mg and Baclofen 10 mg to Resident #H.</p> <p>Interview with LPN #4 on 12-13-11 at 2:42 p.m., indicated Resident #H's Hydrocodone 7.5/500 mg, Reglan 5 mg, Oxcarbazepine 150 mg and Baclofen 10 mg were given late as they were ordered to be given at 8:00 p.m.</p> <p>Review of the clinical record on 12-14-11 at 10:45 a.m., indicated the physician recap dated December 2011 for Resident #H indicated the resident was ordered Baclofen 10 mg 1 tab by mouth 3 times a day at 4 a.m., 12 p.m., &amp; 8 p.m., Hydrocodone/APAP 7.5/500 mg 1 tab by mouth 3 times a day at 4 a.m., 12 p.m., &amp; 8 p.m., Oxcarbazepin 150 mg 1 tab by</p>		<p>before or after the scheduled time. Corrective action will be QA monitored using the Medication Pass Procedure and Medication Error Review audit tools. These QA tools will be used by the DON, ADON or Designee daily x 1 week, then weekly x 4 weeks, then monthly x 6 months to ensure medications are being administered as ordered and to ensure all medications are being administered either 60 minutes before or after the scheduled time. This process will be monitored using the Quality Improvement Tool-Medication Pass Procedure Review and the Medication Error Review. The results will be reviewed by the Quality Assurance Committee and any recommendations made will be implemented.</p>		

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	<p>mouth 2 times a day at 4 a.m. &amp; 8 p.m. and Reglan 5 mg 1 tab by mouth 4 times a day at 4 a.m., 12 p.m., 4 p.m. and 8 p.m.</p> <p>3. During medication pass observation on 12-12-11 at 10:20 p.m., LPN #4 prepared and administered Colace 100 mg, Relafen 500 mg and Rifampin 300 mg to Resident #I.</p> <p>Interview with LPN #4 on 12-13-11 at 2:42 p.m., indicated Resident #I's Colace 100 mg, Relafen 500 mg and Rifampin 300 mg were given late. LPN # 4 indicated it had been a really busy night and that was why the medications were given late.</p> <p>Review of the clinical record on 12-14-11 11:05 a.m., the physician recap dated December 2011 for Resident #I indicated the resident was ordered Colace 100 mg 1 tab by mouth 2 times a day at 8 a.m. and 8 p.m. for constipation, Relafen 500 mg 1 tab by mouth 2 times a day at 8 a.m. &amp; 5 p.m. for musculoskeletal pain and Rifampin 300 mg 1 tab by mouth 2 times a day at 8 a.m. and 8 p.m. for wound infection.</p> <p>The "Medication Administration Procedure" policy provided by the Director of Nursing on 12-15-11 at 10:30 a.m. indicated " Ensure that the resident</p>				

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	<p>receives the med at the correct time- 60 min before or after the scheduled time."</p> <p>This federal tag relates to complaint IN00100626.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>				