

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/18/2016
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
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F 0000  Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00197482.</p> <p>Survey dates: April 11, 12, 13, 14, 15, and 18, 2016.</p> <p>Facility number: 000174 Provider number: 155274 AIM number: 100274810</p> <p>Census bed type: SNF: 3 SNF/NF: 52 Total: 55</p> <p>Census payor type: Medicare: 8 Medicaid: 36 Other: 11 Total: 55</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on April 25, 2016.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F 0157	<b>F157D NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b>	04/22/2016

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	<p>a physician was immediately notified a resident expressed a statement of self-harm for 1 of 19 residents in the Stage 2 sample. (Resident G)</p> <p>Findings include:</p> <p>On 4/11/16 at 10:25 A.M., Resident G was observed laying in bed.</p> <p>The clinical record of Resident G was reviewed on 4/13/16 at 1:58 P.M. The record indicated the diagnoses of Resident G included, but were not limited to, dementia with behavioral disturbance.</p> <p>The most recent Quarterly MDS (Minimum Data Set) Assessment dated 2/23/16 indicated Resident G experienced moderate cognitive impairment and no thoughts of self-harm.</p> <p>A Significant Change MDS dated 3/24/16 indicated Resident G experienced severe cognitive impairment and no thoughts of self-harm.</p> <p>A Nursing Progress note dated 3/26/16 at 7:08 P.M. indicated, "Resident stated to 3 staff members 'I want to cut my throat with a knife'. HFA notified and family. Resident was put on 15 minute checks. All potentially harmful objects were</p>		<p>It is the policy of Miller's Merry Manor, Rockport to promptly inform the resident, consult with the resident's physician, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status and/or the need to alter treatment significantly.</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>Resident G – Physician was notified on 3/28/2016 of resident expressing a statement of self-harm.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice?</b></p> <ul style="list-style-type: none"> <li>All residents have the potential to be affected by the alleged deficient practice.</li> </ul> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>All licensed nursing staff will be in-service on facility policy for <u>Physician and Family Notification of Changes</u> (Attachment A) on 4/22/2016.</li> <li>All new condition changes will be monitored by nurse management team by reviewing Point Click Care's 24 Hour Condition Report to ensure</li> </ul>		

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	<p>removed from resident's room." The note lacked any documentation to indicate the attending physician was immediately notified of the self-harm statement.</p> <p>A consecutive Nursing Progress note dated 3/27/16 at 4:34 P.M. indicated, "Resident stated 'I would be better off dead.' Resident's son here today and resident told son the same thing. Resident's son reassure [sic] resident that he was gonna start feeling better and not to think like that." Resident remains on 15 min [minute] checks. The note lacked any documentation to indicate the attending physician was immediately notified of the self-harm statement.</p> <p>A consecutive late entry Nursing Progress note dated 3/28/16 at 5:04 A.M. indicated, "No concerns on this shift. 15 minute checks continue." The note lacked any documentation to indicate the attending physician was immediately notified of the self-harm statement.</p> <p>A consecutive Nursing Progress note dated 3/28/16 at 10:42 A.M. indicated, "[name of attending physician] notified of statements made over the weekend regarding pt [patient] would be better off dead. This rn [registered nurse] request antidepressant and [name of psychiatric</p>		<p>family/responsible party and physician notification. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> <u>24 Hour Condition Report Review</u> QA tool (Attachment B) will be utilized 5 X a week X 4 weeks, weekly X 1 month, and monthly thereafter to ensure timely and appropriate physician and family notification. Any identified trends will be corrected upon discovery, documented on facility QA tracking log, and reported during monthly QA Committee meeting overseen by the Administrator.</p>				

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	<p>unit] eval [evaluation]. Awaiting response." (The attending physician was not notified Resident G expressed a statement of self-harm for 39 hours and 34 minutes).</p> <p>A Care Plan for, "Resident verbalized a suicidal comment. Resident will be placed on modified suicide precautions" dated 3/28/16 included, but was not limited to interventions of, "The physician will be contacted immediately regarding any change in the resident's condition"</p> <p>During an interview on 4/14/16 at 8:45 A.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate the attending physician was immediately notified Resident G expressed a statement of self-harm.</p> <p>The Policy and Procedure for Suicide Prevention provided by the Regional HFA (Health Facility Administrator) on 4/14/16 at 10:55 A.M. indicated, "...When residents verbalize the intent...an attempt at suicide..The charge nurse will notify the physician of the residents [sic] change of condition and to obtain further instructions...The physician should be contacted immediately..."</p>			

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F 0250 SS=D Bldg. 00	<p>3.1-5(a)(1) 3.1-5(a)(3)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure Social Services were provided after a resident expressed a statement of self-harm for 1 of 1 resident who met the criteria for review of Social Services. (Resident G)</p> <p>Findings include:</p> <p>On 4/11/16 at 10:25 A.M., Resident G was observed laying in bed.</p> <p>The clinical record of Resident G was reviewed on 4/13/16 1:58 P.M. The record indicated the diagnoses of Resident G included, but were not limited to, dementia with behavioral disturbance.</p> <p>The most recent Quarterly MDS (Minimum Data Set) Assessment dated 2/23/16 indicated Resident G experienced moderate cognitive</p>	F 0250	<p><b>F250D PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b></p> <p>It is the policy of Miller's Merry Manor, Rockport to identify the health-related psychosocial needs of the residents and provideservices for the identified needs.</p> <p><b>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by this deficient practice?</b></p> <p>·All residents have the potential to beaffected by the alleged deficient practice.</p> <p><b>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?</b></p> <p>·All residents have the potential to beaffected by the alleged deficient practice.</p> <p><b>Whatmeasures will be put into place or what systemic changes you will make</b></p>	05/09/2016			

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	<p>impairment, and no thoughts of self-harm.</p> <p>A Significant Change MDS dated 3/24/16 indicated Resident G experienced severe cognitive impairment and no thoughts of self-harm.</p> <p>A Nursing Progress note dated 3/26/16 at 7:08 P.M. indicated, "Resident stated to 3 staff members 'I want to cut my throat with a knife. HFA notified and family. Resident was put on 15 minute checks. All potentially harmful objects were removed from resident's room."</p> <p>The Social Service Progress notes from 3/26/16 through 4/12/16 lacked any documentation.</p> <p>A Care Plan for, "Resident verbalized a suicidal comment. Resident will be placed on modified suicide precautions" dated 3/28/16 included the following interventions:</p> <p>Residents [sic] room will be checked thoroughly for all potentially harmful items such as files, clippers, razor blades, sharp pointed items, aerosol cans, medications, peri-wash, aftershave, belts, scarves, etc [et cetera] and any harmful items has [sic] been removed from room and/or out of reach if resident unable to</p>		<p><b>toensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>All nursing and social services staffwill be in-serviced on <u>Suicide Precautions Procedure</u> (Attachment C)completion date 5/6/2016.</li> <li>MSW was re-educated on 5/9/2016 onmonitoring the 24 Hour Condition Report for social service needs as well as <u>Stressorsthat Should be Assessed</u> policy (Attachment D).</li> </ul> <p><b>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>Social Service NeedsQA tool (Attachment E) will be completed by MSW weekly X 4 weeks and monthlythereafter.</li> <li>Any identified trends will be correctedupon discovery, documented on facility QA tracking log, and reported duringmonthly QA Committee meeting overseen by the Administrator.</li> </ul>		

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	<p>get out of bed,</p> <p>Diet will be ordered with disposable dishes and utensils, (if appropriate),</p> <p>The resident is checked q [every] 15 min and appropriate documentation made regarding the residents [sic] condition in the medical record,</p> <p>The physician will be contacted immediately regarding any change in the resident's condition,</p> <p>Refer to psych [psychiatric] services and/or clergy if appropriate. Resident transferred to [name of hospital]"</p> <p>During an interview on 4/14/16 at 8:45 A.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate Social Services were provided to Resident G after the statement of self-harm on 3/26/16.</p> <p>The Policy and Procedure for Suicide Prevention provided by the Regional HFA (Health Facility Administrator) on 4/14/16 at 10:55 A.M. indicated, "...When residents verbalize the intent...an attempt at suicide...SS [Social Service] Director will visit the resident at their earliest convenience to do appropriate interventions and</p>			

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F 0282 SS=D Bldg. 00	<p>documentation...The SSD [Social Services Designee] ...will do a minimum daily visit with the resident with appropriate documentation in the SS notes..."</p> <p>3.1-34(a) 3.1-34 (a)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a physician's order to change advanced directives from CPR to DNR was recorded accurately in both the electronic and the paper medical record for 1 of 2 resident's reviewed for advanced directives. (Resident #48)</p> <p>Findings include:</p> <p>On 4/12/16 at 9:11 A.M., Resident #48 was observed sitting in a wheelchair with no distress noted.</p>	F 0282	<p><b>F282D SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>It is the policy of Miller's Merry Manor, Rockport to ensure physician orders are transcribed correctly and carried out per plan of care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>·Resident #48 – Correction of code status was documented on the resident's face sheet on 4/12/2016. Resident did not encounter any negative outcome from this transcription error.</p>	05/06/2016

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	<p>On 4/12/16 at 10:36 A.M., Resident #48's clinical record was reviewed. Resident #48 had been admitted to the facility on 7/3/13. Her diagnoses included, but were not limited to, intra-abdominal pelvic mass, heart failure, and dementia.</p> <p>The Physician's Orders for Resident #48 dated April 2016 included, but were not limited to, "Change code status to dnr [Do Not Resuscitate] ...verbal...Order Date...4/8/16..."</p> <p>1. During a review of Resident #48's electronic medical record on 4/12/16 at 10:00 A.M., the following was observed:</p> <p>The Clinical Resident Profile on Resident #48's electronic medical record documented the following, "Code Status: CARDIOPULMONARY RESUSCITATION (CPR)..."</p> <p>A Progress Note located in Resident #48's electronic medical record dated 4/6/16 read as follows: "late entry...Son signed DNR [Do Not Resuscitate] papers..."</p> <p>2. During a review of the paper medical record on 4/12/14 at 11:00 A.M., the following was observed:</p> <p>The medical record was observed to have</p>		<p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All residents have the potential to be affected by the alleged deficient practice.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>All licensed nursing staff were in-service on <u>Charting Procedure</u> (Attachment F) and <u>Code Status and Advanced Directive Determination</u> (Attachment G) on 4/22/2016.</li> <li>All present residents' medical records accurately reflect their code status completion date 5/6/2016.</li> <li>All entered orders are verified by two licensed nurses to ensure accuracy in transcription beginning 5/1/2016.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>All orders are verified by designated nurse manager to assure correct transcription and verified by two nurses.</li> </ul>				

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	<p>a blue dot placed on the spine of the binder.</p> <p>A DNR paper form located in the medical record indicated Resident #48's code status to be DNR. The DNR form had been signed by the physician on 4/7/16 and Resident #48's son on 4/5/16.</p> <p>The April 2016 Medication Administration Record (MAR) indicated Resident #48 had a physician's order dated 10/21/14 to receive cardiopulmonary resuscitation (CPR).</p> <p>The policy for "Advanced Directives &amp; Code Status Procedure" provided by the Director of Nursing on 4/12/16 at 2:34 P.M., read as follows: "...After a CPR decision has been made , the form signed by the resident/family will be placed in the medical record...will be communicated to the nurse in charge of caring for the resident..."</p> <p>During an interview on 4/12/16 at 11:05 A.M., RN #16 and RN #18 were sitting at the nurses' station on the East hall. RN #16 and RN #18 indicated the blue dot located on the outside of the resident's chart reflected the resident's code status and that the resident was supposed to receive CPR if a blue dot was located on the outside of the resident's chart. Both</p>			

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F 0309 SS=D Bldg. 00	<p>RN's indicated during an emergency they would check to see if a blue dot was located on the medical record. RN #16 was sitting at the computer and pointed to the Clinical Resident Profile screen and indicated the code status could also be found in the electronic medical record. RN #18 indicated there was also a code status paper that was signed and located in the medical chart.</p> <p>During an interview on 4/19/16 at 3:30 P.M., the Regional Health Care Administrator was made aware of the discrepancies between the electronic medical record and the paper medical record concerning Resident #48's advance directive for CPR.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff responded to a resident's calls for</p>	F 0309	<b>F309D PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b> It is the policy of Miller's Merry Manor,	05/09/2016

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	<p>help for 1 of 1 random observation of a resident calling out for help. (Resident G)</p> <p>Findings include:</p> <p>During a random observation on 4/11/16 at 10:25 A.M., Resident G was observed from the hallway through a partially opened door, laying in bed and repeatedly calling out, "Help me! Help me!" During a continuous observation through 10:45 A.M., Resident G continued to repeatedly call out "Help me!" and no staff members were observed to enter the room of Resident G.</p> <p>During an interview on 4/11/16 at 10:45 A.M., RN #10 was made aware Resident G was calling for help and stated, "He does that all the time, he doesn't want anything, he just does that."</p> <p>During an observation on 4/11/16 at 10:51 A.M., the SSD (Social Service Designee) was observed to enter the room of Resident G.</p> <p>The clinical record of Resident G was reviewed on 4/13/16 1:58 P.M. The record indicated the diagnoses of Resident G included, but were not limited to, dementia.</p> <p>During an interview on 4/14/16 at 8:00</p>		<p>Rockportto ensure staff respond to residents who exhibit behavioral, mental, physical, or psychosocial symptoms in a dignified manner; and maintain resident quality of life and the safety of residents and others.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>Resident G – Resident was sent out for medical attention and has returned with no negative outcomes.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All residents have the potential to be affected by the alleged deficient practice.</li> </ul> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>RN #10 was educated on 4/14/2016 on responding promptly to residents' requests for help.</li> <li>All licensed staff were in-serviced on the need to respond to yelling out on 4/22/2016.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p>				

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F 0323 SS=E Bldg. 00	<p>A.M., the DON (Director of Nursing) indicated no specific policy could be provided, but it is usual facility practice for staff to respond to a resident's call for help immediately.</p> <p>3.1-37(a)</p> <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.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure a gait belt was used to properly transfer 2 of 2 residents randomly observed for transfers and 1 of 1 resident interviewed confidentially for transfers. (Resident B, Resident C, Resident D)</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided and new, immediate interventions were implemented for 2 of 4 residents who met the criteria for review of Accidents. (Resident H, Resident E)</p>	F 0323	<p>Resident Dignity QA tool (Attachment H) will be utilized by nurse management team weekly X 4 weeks and monthly thereafter completion date 5/9/2016.</p> <p>Any identified trends will be corrected upon discovery, documented on facility QA tracking log, and reported during monthly QA Committee meeting overseen by the Administrator.</p> <p><b>F323E FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b> It is the policy of Miller's Merry Manor, Rockport to ensure safety in transfer and ambulation. To provide a point of contact and increased support from the staff and prevent injuries to staff and residents who are unable to transfer or ambulate independently. Gait belts will be used as indicated on the individual's plan of care (A). Assess all residents for risk factors that may contribute to falling and to provide planned interventions identified by the</p>	05/13/2016	

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	<p>Findings include:</p> <p>A. 1. During a random observation of the East 1 lounge on 4/11/16 at 9:00 A.M., CNA #5 and RN #10 were observed to not apply a gait belt, grasp the bilateral upper arms, pull Resident C into a standing position, and transfer from a recliner to a wheelchair without using a gait belt.</p> <p>The CNA Assignment Sheets provided by UM (Unit Manager) #1 on 4/11/16 at 10:15 A.M. indicated Resident C required the assistance of 1-2 staff for transfers. The Assignment Sheet lacked any documentation related to the use of a gait belt.</p> <p>A. 2. During a random observation of the East 1 lounge on 4/11/16 at 9:10 A.M., CNA and RN #10 were observed to not apply a gait belt, grasp the bilateral upper arms, pull Resident D into a standing position, and transfer from a recliner to a wheelchair without using a gait belt.</p> <p>The CNA Assignment Sheets provided by UM (Unit Manager) #1 on 4/11/16 at 10:15 A.M. indicated Resident D required the assistance of 1-2 staff for transfers. The Assignment Sheet lacked</p>		<p>team as appropriate for resident use in maintaining or returning to the highest level of physical, social, and psychosocial functioning as possible (B). <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>·(A). ·Resident B – Care plan and CNA assignment sheets have been update to include the use of a gait belt intranfers completion date 5/6/2016. ·Resident C – Care plan and CNA assignment sheets have been updated to include the use of a gait belt intranfers completion date 5/6/2016. ·Resident D – Care plan and CNA assignment sheets have been updated to include the use of a gait belt intranfers completion date 5/6/2016. ·(B.) ·Resident H – Laying down after meals and when tired was added to the health care plan and CNA assignment sheet on 3/29/2016. ·Resident E – Is no longer a resident at this facility. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> ·All residents have the potential to be affected by the alleged deficient practice.</p>		

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	<p>any documentation related to the use of a gait belt.</p> <p>A. 3. During a confidential interview on 4/11/16 at 12:07 P.M. Resident B indicated staff used to transfer him/her by grasping underneath his/her arms. The Resident further indicated staff did not use a gait belt to transfer him/her.</p> <p>The most recent Quarterly MDS dated 1/18/16 indicated Resident B experienced no cognitive impairment.</p> <p>During an interview on 4/14/16 at 8:00 A.M., the DON (Director of Nursing) indicated the residents should not have been transferred by staff by grabbing underneath the arms and a gait belt should have been used.</p> <p>The Policy and Procedure for Gait Belt Use Procedure provided by the MDS Nurse on 4/14/16 at 12:09 P.M. indicated, "...to insure [sic] safety in transfer and ambulation. To provide a point of contact and increased support from the staff and prevent injuries to staff and resident who are unable to transfer or ambulate independently..."</p> <p>B. 1. During an observation on 4/11/16 at 3:34 P.M., Resident H was observed sitting in a wheelchair in the East 1</p>		<p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·All resident's fall care plans reviewed by nurse management team to ensure accuracy and appropriate interventions completion date 5/13/2016.</li> <li>·All nursing staff were educated on the <u>GaitBelt Use Procedure</u> (Attachment I) on 4/22/2016 and 5/6/2016.</li> <li>·All licensed nursing staff were in-serviced on <u>Fall Management Procedure</u> (Attachment J) and <u>Interventions/Protocol List</u> (Attachment K) completion date 4/22/2016.</li> <li>·Interdisciplinary team will review all falls to determine root cause and establish proper interventions. Resident's plan of care updated accordingly and new interventions communicated to staff completion date 5/1/2016.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·<u>Fall Risk Management Review QA Tool</u> (Attachment L) will be utilized by nurse management team for all falls weekly X 4 weeks and monthly thereafter completion date 5/18/2016.</li> <li>·Any identified trends will be</li> </ul>		

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	<p>lounge with head down and eyes closed.</p> <p>During an interview on 4/12/16 at 10:02 A.M., UM #1 indicated Resident H experienced an unwitnessed fall with injury on 3/19/16 in the East 1 unit lounge by the nursing station. UM #1 indicated Resident H dozed off while sitting in a wheelchair, fell forward, and hit his head on the floor. UM #1 further indicated, a new intervention of laying Resident H down after meals if staff noticed he was drowsy, was implemented. UM #1 then indicated, Resident H was at risk to experience falls.</p> <p>The clinical record of Resident H was reviewed on 4/13/16 at 2:39 P.M. The record indicated the diagnoses of Resident H included, but were not limited to, Alzheimer's.</p> <p>The most recent Quarterly MDS dated 3/9/16 indicated Resident H experienced severe cognitive impairment, required the extensive assistance of two staff for transfers, did not have a history of falls, and had not experienced any falls during the previous assessment period.</p> <p>A Care Plan for Fall Risk dated 1/9/16 indicated the following interventions: "anti-rollback placed on W/C</p>		corrected upon discovery, documented on facility QA tracking log, and reported during monthly QA Committee meeting overseen by the Administrator.	

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	<p>[wheelchair] to stabilize w/c, toilet before every supper and every 2 hours, pommel cushion to w/c to prevent sliding forward out of wheelchair, direct supervision, analyze previous resident falls to determine whether pattern/trend can be addressed, call light in reach. Explain use of it upon admission and reinforce as needed, encourage and assist with wearing non-skid foot-wear, encourage resident to use handrails or assistive devices properly, evaluate effectiveness and side effects of psychotropic drugs with physician for possible decrease in dosage/elimination of medication, monitor for changes in gait/positioning, notify MD of changes in condition, notify Therapy of changes in condition, reassess fall risk factors annually and PRN."</p> <p>A Care Plan for Fall Risk dated 1/30/15 indicated the intervention of "direct supervision" was discontinued. The Care Plan lacked any documentation to indicate a new intervention was implemented to ensure the safety of Resident H.</p> <p>A Nursing-Occurrence Initial Assessment dated 3/19/16 at 10:17 A.M. indicated,</p>			

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	<p>Resident H experienced an unwitnessed fall with injury on 3/19/16 at 10:00 A.M. The Assessment further indicated, "Resident was in wheel chair [sic] and fell out of wheelchair in hall 1 lobby. Staff members at nurses station however fall was unwitnessed..." The Assessment lacked any documentation to indicate a new, immediate intervention was implemented to ensure the safety of Resident H.</p> <p>A Facility-Post Occurrence IDT a fall (sic) risk(sic) Assessment dated 3/20/16 at 7:25 A.M. indicated a new intervention of "...lay resident down in bed or transfer to recliner...anytime...noted to be drowsy"</p> <p>During an interview on 4/18/16 at 3:15 P.M., the DON (Director of Nursing ) indicated no documentation could be provided to indicate a new, immediate intervention was implemented before 3/20/16 at 7:35 A.M.</p> <p>B. 2. The clinical record of Resident E was reviewed on 4/13/16 at 3:17 P.M. The record indicated the diagnoses of Resident E included, but were not limited to, dementia.</p> <p>During an observation on 4/11/16 at 8:45 A.M. Resident E was observed sitting in</p>			

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	<p>a wheelchair in the East 1 Unit. Resident E was observed, at that time, to have facial bruising from the forehead to the neck.</p> <p>During an interview on 4/11/16 at 9:00 A.M., UM #1 indicated Resident E experienced frequent falls and had experienced a fall from bed within the last 7 days. UM #1 further indicated, at that time, the 1/2 side rail was removed and the bed frame was padded as immediate interventions.</p> <p>The most recent Significant Change MDS dated 10/28/16 indicated Resident E experienced severe cognitive impairment required the extensive assistance of two staff for transfers, and had a history of falls.</p> <p>The most recent Quarterly MDS dated 2/4/16 indicated Resident E experienced severe cognitive impairment, required the extensive assist of two staff for transfers, and had experienced no falls during the previous assessment period.</p> <p>A Care Plan dated 3/2/16 for Falls indicated the following interventions: toileting schedule, night light placed in room, call light within reach when in room, encourage and assist with wearing</p>			

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	<p>non-skid foot-wear, evaluate effectiveness and side effects of psychotropic drugs with physician for possible decrease in dosage/elimination of medication, lip mattress, low bed with mat at bedside while in bed, bed against wall, move w/c's [wheelchairs] away from resident, notify MD of changes in condition reassess fall risk factors annually and PRN, Resident to be in common area when up in w/c Provide diversion and/or activity, Resident to be transferred from w/c to couch when in the lounge."</p> <p>Fall #1 A Nursing-Occurrence Initial Assessment dated 4/5/16 at 2:34 A.M. indicated, "Walking by resident's room and saw resident laying on mat by bed. States was nauseated and tried to get up...Denies injury or hitting head but has bruising around right eye" The assessment lacked any documentation to indicate a new, immediate intervention was implemented to ensure the safety of Resident E.</p> <p>An Incident Investigation dated 4/5/16 indicated Resident E experienced an unwitnessed fall on 4/5/16 at 9:30 P.M. The Investigation further indicated</p>			

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	<p>Resident E was toileted at 9:25 P.M., previously planned interventions were not effective and the immediate interventions implemented was, "toilet resident". The Investigation lacked any documentation to indicate a new, immediate intervention was implemented after the fall.</p> <p>The Nursing Progress notes from 4/3/16 at 3:02 P.M. through 4/6/16 at 10:11 A.M. lacked any documentation to indicate a new immediate intervention was implemented to ensure the safety of Resident E.</p> <p>A Facility-Post Occurrence IDT (Interdisciplinary Team) and fall (sic) risk (sic) Assessment dated 4/6/16 at 10:37 A.M. indicated a new intervention of, "remove 1/2 SR [side rail] and pad the entire length of the bed frame on the right side of bed" was implemented.</p> <p>During an interview on 4/18/16 at 3:00 P.M. the DON (Director of Nursing) indicated she did not know the exact time the side rail was removed and the bed frame was padded, but no documentation could be provided to indicate a new, immediate intervention was implemented before 4/6/16 at 10:37 A.M.</p> <p>The Policy and Procedure for Falls</p>			

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F 0458 SS=E Bldg. 00	<p>Management provided by the HFA on 4/18/16 at 1:55 P.M., indicated, "...If a fall occurs...determine what new or revised interventions will be implemented to reduce the risk of further falls..."</p> <p>3.1-45(a)</p> <p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on record review, observation, and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple residents' rooms and 100 sq ft in single occupancy rooms. This was evidenced in 14 of 42 resident rooms in the facility. Rooms 3, 5, 7, 9, 13, 17, 19, 21, 22, 23, 24, 25, 10, 16.</p> <p>Findings include:</p> <p>The Bed Inventory dated 4/11/16, was provided by the Regional Administrator on 4/11/16 at 2:08 P.M., and indicated the following rooms had room size</p>	F 0458	<p><b>F458E BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT</b> The facility has requested a waiver for the rooms cited in the survey. The facility does not feel that the size of the rooms cited has any adverse affect on the residents in those rooms. CMS has granted the waiver in years past.</p>	04/22/2016

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	<p>waivers. The Waiver certification dated 3/18/15, was reviewed at that time. During an environmental tour the following room sizes of observed rooms:</p> <p>*1. Room #3 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*2. Room #5 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*3. Room #7 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*4. Room #9 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*5. Room #13 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*6. Room #17 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*7. Room #19 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*8. Room #21 2 beds 154.65 sq ft</p>			

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	<p>SNF/NF 77.32 sq ft per resident</p> <p>*9. Room #22 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*10. Room #23 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*11. Room #24 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*12. Room #25 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>These room sizes were verified by the Administrator on 4/18/16 at 08:10 A.M., as well as the room sizes of two additional single occupancy rooms which were observed to have less than 100 sq ft as follows:</p> <p>*13. Room #10 1 bed 90.52 sq ft per resident</p> <p>*14. Room #16 1 bed 90.52 sq ft per resident</p> <p>3.1-19(1)(2)</p>			

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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
F 0502 SS=D Bldg. 00	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on observation, interview, and record review, the facility failed to ensure lab results were obtained for 1 of 1 resident reviewed for routine labs. (Resident C)</p> <p>Findings include:</p> <p>On 4/15/16 at 8:10 A.M., Resident C was observed asleep in her low bed with no distress noted.</p> <p>Resident C's clinical record was reviewed on 4/18/16 at 9:02 A.M. Resident C had been admitted to the facility on 3/22/11. Her diagnoses included but were not limited to, hypertension, chronic obstructive disease, Alzheimer's disease, and edema. Her current physician orders with an order date of 4/17/15, included but was not limited to, "CBC [Complete Blood Count], CMP [Complete Metabolic Panel], ... EVERY 3 MONTHS (May, Aug. Nov, Feb)..."</p> <p>On 4/18/16 at 9:11 A.M., a lab report dated 2/9/16 was reviewed with Resident</p>	F 0502	<p><b>F502D ADMINISTRATION</b></p> <p>It is the policy of Miller's Merry Manor, Rockport to obtain labs as ordered by the physician.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>Resident C – The lab was redrawn on 4/18/2016.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</b></p> <ul style="list-style-type: none"> <li>All residents with lab orders are at risk to be affected by the alleged deficient practice.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>All lab orders and results to be monitored by designated nurse manager to ensure orders are being followed.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</b></p>	05/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/18/2016
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	<p>C's nurse, LPN #4. The lab report indicated, "COMP [complete] METABOLIC PROFI [profile] REQUEST CREDITED HEMOLYZED, RECOLLECT PROCESS INITIATED..."</p> <p>LPN #4 was made aware documentation was lacking in the clinical of the CMP lab result of the 2/9/16 lab or a CMP lab result after the 2/9/16 date. LPN #4 indicated, at that time, she would contact the hospital lab to see if another CMP had been drawn.</p> <p>A nursing progress note dated 4/18/16 at 9:51 A.M., indicated, "spoke [sic] with [employee of lab] at [hospital name] lab regarding CMP [complete metabolic panel], BC [complete blood count] that was scheduled to be drawn on 2/9/16. stated [sic] blood had hemolized and stated their policy is to rerun the same day or next morning to redraw et noted draw was not done. will [sic] come out today to redraw stat (sic)"</p> <p>On 4/18/16 at 10:12 A.M., review of the clinical record with LPN #4 , indicated a fax note (dated 1/8/16) to the physician had included, but was not limited to, the medication potassium had been refused 3 of 7 days. The physician note included, but was not limited to, discontinuing the potassium and checking the potassium on the next lab day. LPN #4 indicated a</p>		<p><b>i.e., quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·Designated nurse manager will implement <u>LaboratoryReview</u> QA tool (Attachment M) weekly X 4 weeks and monthly thereafter.</li> <li>·Any identified concerns will becorrected upon discovery, documented on facility QA tracking log, and reportedduring monthly QA Committee meeting overseen by the Administrator.</li> </ul>	

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	<p>potassium lab had been drawn on 1/12/16 and indicated a low result of 2.8 (reference range of 3.5-5.4).</p> <p>A progress note dated 1/12/16 at 3:02 P.M., indicated a potassium level had been drawn and sent to the physician. "... Results sent to [physician's name] with order recd [received] to increase potassium..." On 4/18/16 at 10:12 A.M., LPN #4 indicated that had been when the resident's potassium medication had been restarted.</p> <p>On 4/18/16 at 2:50 P.M., during interview with LPN #4, she indicated hospital lab staff had been at the facility today and had drawn the CBC and CMP that had been scheduled for 2/9/16.</p> <p>On 4/18/16 at 2:05 P.M., the Director of Nursing (DON) was interviewed and indicated she was unable to provide a facility policy regarding the checking and monitoring of lab services provided to the facility.</p> <p>3.1-49(a)</p>			