

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2016
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 5909 LUTE RD PORTAGE, IN 46368
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00204651.</p> <p>Complaint IN00204651 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314.</p> <p>Survey date: July 12, 2016</p> <p>Facility number: 000196 Provider number: 155299 AIM number: 100267390</p> <p>Census bed type: SNF: 4 SNF/NF: 52 Total: 56</p> <p>Census payor type: Medicare: 7 Medicaid: 35 Other: 14 Total: 56</p> <p>Sample: 6</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on</p>	F 0000	<p>This Plan of Correction shall serve as this Facility's Credible Allegation of Compliance. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements Please consider allowing the submission of Facility audits and education as evidence of compliance with the state and federal requirements identified in the survey.</p> <p>Respectfully Submitted, Beth Ingram Executive Director</p>	
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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 0314 SS=D Bldg. 00	<p>7/13/15.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing related to nutritional assessments not completed, Registered Dietician recommendations not implemented, and wound care treatments not in place for 3 of 3 residents reviewed for pressure ulcers in a sample of 6. (Residents #B, #D, and #E)</p> <p>Findings include:</p> <p>1. On 7/12/16 at 8:55 a.m., Resident #D was observed in bed. There was a low air loss mattress on the resident's bed. The Director of Nursing was present at this time and removed the resident's brief to</p>	F 0314	<p>Step 1 Resident E discharged home prior to survey. The Dietary Recommendations from 6/21/16 for Resident B was reviewed by the physician on 7/12/16 and the recommendation was declined. Resident D's Dressing was replaced promptly once the Nurse was notified Step 2 Records for Residents with Pressure Ulcers were reviewed for Dietary assessment and all were in place. Dietary Recommendation for the last 30 days were reviewed for follow up and corrected as required. Dressing placement was checked for all residents with wounds and none were found missing. Step 3 The Dietary Manager and Registered Dietician were re-educated regarding the need for early assessment of residents with</p>	07/29/2016			

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	<p>observe the coccyx wound area. Two open areas were noted on the resident's coccyx. There were no dressings in place over the wounds. No dressings were observed in the bed. The two open areas were approximately 2 cm x 1 cm each. No drainage was noted. The resident was incontinent of stool at this time. Stool was noted in the brief and on the resident left buttock area. CNA#1 entered the room to provide incontinence care.</p> <p>The record for Resident #D was reviewed on 7/12/16 at 10:50 a.m. The resident's diagnoses included, but were not limited to, pressure ulcer, chronic obstructive pulmonary disease, and anxiety disorder.</p> <p>The 6/30/16 Admission Nursing assessment indicated the resident was admitted with a pressure ulcer to the coccyx. The wound edges were round. The wound measured 6.0 cm (centimeters) x 1.5 cm. The edges around the wound were red and red/yellow slough (necrotic or avascular tissue in the process of separating from viable tissue) was present to the inside of the wound.</p> <p>Review of the 7/2016 Physician orders indicated an order was written on 7/1/16 to cleanse and dry the skin around the wound, apply skin prep to the periwound,</p>		<p>pressure ulcers. Nurses were re-educated to promptly follow up on Dietary recommendations. Nursing staff were re-educated regarding the need to promptly inform nurses when a dressing is not in place, and for Nurses to re-dress a wound when a dressing is not in place. Step 4 The Executive Director or her Designees will audit; Early Dietary Assessment, Prompt follow up to Dietary recommendations and prompt follow up when a dressing is not in place will be audited as follows; All resident with pressure ulcers three times weekly for 4 weeks, then five residents with pressure ulcers twice weekly for the next 4 weeks, then five weekly for the next 4 months. Audit results will be reviewed during clinical start up. Audit results will be reviewed monthly in QA for trends no less than six months. The QA team will make recommendation to alter the plan, including need to resolve audits.</p>		

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	<p>and apply a calcium alginate foam adhesive dressing on the wounds every three days on the night shift and as needed. Review of the 7/2016 Treatment Administration Record indicated the ordered treatment was last signed out as completed during the night shift on 7/10/16.</p> <p>The first Wound-Pressure Ulcer Assessment was completed on 7/7/16. The Wound-Pressure Ulcer Assessment indicated the coccyx pressure ulcer was a Stage III (full thickness tissue loss with possible presence of slough). The wound measured 1 cm x 1.2 cm x 0.1 cm and the wound edges were attached. The assessment indicated the resident did not have any nutritional supplements in place. There were no other Wound-Pressure Ulcer Assessments related to the second coccyx pressure ulcer. No further assessments were completed after 7/7/16.</p> <p>Review of the CAR (Clinically at Risk) tool indicated the resident was first reviewed on 7/8/16. The tool indicated the resident had two wounds to the coccyx. The resident had not been reviewed after 7/8/16.</p> <p>The first Nutritional note was a "Mini Nutritional Assessment" completed on</p>			

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	<p>7/11/16. The assessment indicated the resident's score was (10). A score of (10) indicated the resident was at risk for malnutrition. The assessment indicated the resident had pressure ulcers and did not receive any nutritional supplements.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 7/11/16 indicated the resident's nutrition screening score indicated the resident was at risk for malnutrition. No nutritional supplements were listed on the Care Plan. A Care Plan initiated on 7/1/16 indicated the resident was admitted with two pressure areas to the coccyx. Care plan interventions included for staff to administer wound care treatments as ordered.</p> <p>When interviewed on 7/12/16 at 9:10 a.m., CNA #1 indicated she had checked the resident last about 1/2 hour after starting her shift at 6:00 a.m. The CNA indicated she opened the brief and checked the resident briefly but did not look at the resident's "bottom" or take the brief off.</p> <p>When interviewed on 7/12/16 at 11:08 a.m., CNA #2 indicated she was working a split assignment and had provided incontinence care to the resident last at approximately 7:30 a.m. this morning.</p>			

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	<p>The CNA indicated the resident had open wounds to the coccyx area and no wound dressings were on the open areas or noted in the bed. The CNA indicated the resident had stated her bottom had been hurting. CNA #2 indicated she repositioned the resident and the resident had no further complaints of pain. The CNA indicated she did not inform the Nurse of the dressing not being in place over the open area.</p> <p>When interviewed on 7/12/16 at 12:45 p.m., the Director of Nursing indicated the resident should have a dressing on the coccyx wounds as ordered by the Physician.</p> <p>2. The closed record for Resident #E was reviewed on 7/12/16 at 9:29 a.m. The resident's diagnoses included, but were not limited to, pelvic fracture, high blood pressure, chronic obstructive pulmonary disease, and diabetes mellitus. The resident was admitted to the facility on 7/1/16 and was discharged from the facility on 7/9/16.</p> <p>Review of the 7/1/16 Physician admitting orders indicated the resident was to receive a regular diet with nectar thickened liquids. No dietary supplements were ordered.</p>			

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	<p>A Nursing Admission form completed on 7/1/16 at 2:45 p.m. indicated the resident was admitted from the hospital. The Integumentary System Assessment indicated the resident was admitted with a pressure ulcer to the coccyx with yellow slough present.</p> <p>A Wound-Pressure Ulcer Assessment was completed on 7/6/16 at 3:58 p.m. The assessment indicated the resident had a round Unstageable (full thickness tissue loss with the base of wound covered by slough and/or eschar) ulcer to the upper coccyx. The area measured 2 cm x 1.1 cm x .1 cm. The wound bed was 100% yellow slough and no exudate was present. The Physician order indicated the current treatment was to clean the wound with normal saline, pat dry, cover with calcium alginate and a foam dressing on Mondays, Wednesdays, and Fridays, and as needed.</p> <p>The 7/1/16 hospital Discharge Instructions were present in the residents records. The instructions included to cleanse the coccyx with soap and water, skin prep to the peri wound, apply a small amount of wound gel to the wound bed, cover with Aquacel Ag gel and secure with Mepilex dressing daily and as needed.</p>			

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	<p>The 7/2016 Progress Notes were reviewed. No Dietary assessments were noted. No CAR team disciplinary notes were available.</p> <p>The first Registered Dietitian Note was completed on 7/8/16 at 10:47 a.m. The Registered Dietitian note indicated an assessment had been completed and changes were recommended. The recommendations included for the resident to receive 2 Cal HN (a liquid nutritional supplement) 4 ounces at 10:00 a.m. daily to provide an extras 240 calories and 10 grams of protein to promote wound healing.</p> <p>When interviewed on 7/12/16 at 3:45 p.m., the Director of Nursing indicated there was no record of the resident being reviewed in a CAR meeting. The Director of Nursing indicated the CAR meetings were held on 6/29/16 and 7/8/16. The Director of Nursing further indicated no other Dietary Notes or assessments were completed.</p> <p>3. On 7/12/16 at 9:15 a.m., Resident #B was observed in bed. The resident was receiving 1.2 Cal tube feeding formula at 65 cc's per hour. A dressing to the resident's coccyx area was observed with the Director of Nursing present. The dressing was intact.</p>			

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	<p>The record for Resident #B was reviewed on 7/12/16 at 11:00 a.m. The resident's diagnoses included, but were not limited to, sacral pressure ulcer, diabetes mellitus, chronic kidney disease, and seizures. The resident was hospitalized on 5/25/16 and readmitted to the facility on 6/1/16.</p> <p>Review of the 6/9/16 Minimum Data Set (MDS) significant change full assessment indicated the resident was at risk for pressure ulcer and had one unhealed Stage IV (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer. The most severe tissue type was noted as slough.</p> <p>A Progress Note was completed by the RD (Registered Dietitian) on 6/21/16 at 10:55 a.m. The RD note indicated the resident was receiving enteral tube feeding. Recommendations were noted to suggest Prostat Sugar Free (a liquid nutritional supplement) 30 ml (milliliters) once a day to aide in wound healing.</p> <p>Review of the 6/2016 and 7/2016 Physician orders indicated there were no orders for the resident to receive Prostat supplements. Review of the 7/2016 Medication and Treatment Records indicated the Prostate supplement had not</p>			

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	<p>been initiated.</p> <p>The resident was reviewed at CAR meetings on 6/23/16, 6/29/16, and 7/8/16. There was no documentation related to the above RD recommendation for Prostat made on 6/21/16 having been addressed in any of the above CAR meetings.</p> <p>A Pressure Ulcer assessment note completed on 6/22/16 at 2:30 p.m. indicated the resident had a Stage III (full thickness tissue loss with no bone or tendon exposed) to the coccyx. The wound measured 1.8 cm x 1.4 cm x 0.4 cm (centimeters). Tunneling measuring 0.7 cm (centimeters) was noted at 12-1 o'clock. No eschar or slough was noted</p> <p>A Pressure Ulcer assessment note completed on 7/11/16 at 11:15 a.m. indicated the resident had a Stage III pressure ulcer to the coccyx. The wound measured 3 cm x 2.1 cm x 0.1 cm. No tunneling present to the wound.</p> <p>When interviewed on 7/11/16 at 2:30 p.m., the Director of Nursing indicated a note to the Physician was found in the resident's record today. The typed note indicated the RD suggested to add Prostat SF 30 cc's (cubic centimeters) daily to add 15 grams of protein for wound</p>			

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	<p>healing. The Physician signed the paper on 6/24/16 and wrote "OK". The Director of Nursing indicated the order was never entered. The resident had not been receiving any Prostat supplements in June or July.</p> <p>When interviewed on 7/11/16 at 3:30 p.m., the Director of Nursing indicated the resident wound had improved. The Director of Nursing indicated she observed the resident's wound yesterday and no tunneling was noted.</p> <p>The facility policy titled "Skin Management Program" was reviewed on 7/12/16 at 3:30 p.m. The policy was dated March 18, 2014. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated all residents at nutritional risk or pressure ulcer risk were to be referred the Dietary Manager or the Dietitian. The policy indicated Weekly round meetings were to be conducted with the facility wound nurse, dietary manager, and other key nursing staff attending. All wounds were to be discussed and any changes were to be documented. The policy indicated the Dietitian was to be updated weekly with the wound report.</p> <p>The facility policy titled "Pressure Ulcer</p>			

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	<p>Treatment" was reviewed on 7/12/16 at 1:35 p.m. The policy had start date of 8/3/2010. The Director of Nursing indicated provided the policy and indicated the policy was current. The policy indicated all residents with pressure ulcer were to be referred to the Registered Dietitian or Dietary Manager for early assessment and nutritional interventions to provide sufficient calories and adequate protein.</p> <p>This Federal tag relates to Complaint IN00204651.</p> <p>3.1-40(a)(2)</p>			