

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN 47246
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00150075 and IN00152605.</p> <p>Complaint IN00150075 - Unsubstantiated due to lack of evidence. Complaint IN00152605 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: July 21, 22, 23, 23 and 25, 2014</p> <p>Facility number: 000286 Provider number: 155579 AIM number: 100291000</p> <p>Survey Team: Angela Halcomb, RN- TC Rita Bittner, RN Tammy Forthofer, RN Julie Dover, RN Trudy Lytle, RN (7/21, 7/22, 2014)</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 7 Medicaid: 48</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F000157 SS=D	<p>Other: 8 Total: 63</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on August 1, 2014, by Brenda Meredith, R.N.</p> <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</p>				

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	<p>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 record review and interview, the facility failed to notify the physician of increase in a hematoma (bruise). This affected 1 of 1 residents reviewed for hematoma's. (Resident #23).</p> <p>Finding includes:</p> <p>The clinical record for Resident #23 was reviewed on 7/22/14 at 3:28 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbances, osteoporosis, psychosis with hallucinations and abnormal gait.</p> <p>An Incident report, dated 7/1/14, indicated Resident #23 was sitting at the South hall nurses station. Resident #23 had previously been up and ambulated via staff. Resident #23 was visiting with</p>	F000157	F157- Bruise to resident#23 has been resolved. Resident's will have a weekly head to toe skin assessment by the nurse and skin will be checked during showers by the aides. When a bruise is noted the bruise will be measured and charted on for 72 hours. The physician and family will be notified of the bruise. The physicians orders will be followed and notification to physician will be done for any worsening of bruise or injury. This will be put on the 24 hours condition report to ensure that DON, ADON, UM and other staff nurses are aware of monitoring and notifying physician per orders. The nurse will assess the bruise. The licensed nurses will be in-serviced on physician notification, following physician orders and new triple check system in place to ensure that any change of condition will be	08/24/2014

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	<p>others, stood to ambulate and lost balance falling and hitting head on china cabinet and right side on porcelain tile.</p> <p>A nurse's note, dated 7/6/2014, indicated a hematoma that measured 6cm (centimeters) x 7cm was noted on the back of Resident #23's right leg.</p> <p>A physician telephone order, dated 7/6/2014, indicated to draw a line around the hematoma, watch every shift to make sure it does not get bigger.</p> <p>A nurse's note, dated 7/7/14, indicated that the hematoma measured 10cm x 8cm dark purple in color and no tenderness.</p> <p>During an interview with the Director of Nursing (DON) on 7/25/14 at 9:53 a.m., the DON indicated that the physician was not notified of the increase of the hematoma for Resident #23.</p> <p>On 7/25/2014 at 10:39 a.m., the DON provided a copy of the facility's current Policy and Procedure for "Physician and Family Notification of Condition Changes. A. PURPOSE: 1. To keep the physician, resident and family apprised of all condition changes...C. PROCEDURE: 1: Telephone: a. Telephone notification is required for all emergencies or all condition changes that</p>		<p>followed up on. This new process will be monitored using the Occurance notification and follow up QA tool daily X 2weeks then weekly X 6 weeks then monthly thereafter. The results of the QA audits will be reviewed at the monthly QA meeting and any recommendations made will be followed. Person responsible: DON or Designee. Date of completion: 8/24/14</p>				

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	<p>require an immediate response. b. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan...d. Document the information reported to the physician in the nurses notes including the time and date of notification. Be thorough and explicit. e. Document the response from the physician in the nurses notes...."</p> <p>3.1-5 (a)(1)</p>			

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F000160 SS=D	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>Based on interview and record review, the facility failed to ensure individual or probate jurisdiction administering the resident's estate was notified in regard to the final accounting of those funds within 30 days of the death for 1 of 5 residents reviewed for funds. (Resident #70)</p> <p>Finding includes:</p> <p>Resident #70's trust fund statement was reviewed on 7/23/2014 at 3:32 p.m. The trust fund statement was dated 6/30/2014 with a balance of \$422.62. The bottom of the trust form statement had a hand written date of death for Resident #70 of 6/2/2014.</p> <p>During an interview on 7/25/2014 at 10:25 a.m., the Office Manager confirmed Resident #70's date of death was 6/2/2014. The Office Manager</p>	F000160	F160- Upon death of a resident with a personal fund deposited with the facility, within 30 days the resident's estate will be notified in regards to the final accounting of funds. All residents with a resident fund account have the potential to be affected. All residents funds will be returned within 30 days of death of resident. Office manager or designee will audit all resident funds and monitor return of funds for discharged residents on a weekly basis for a period of 12 months then monthly thereafter. The administrator will be notified immediately of any non-compliance and it will be corrected within 24 hours. A QA tool has been developed to track this. Person responsible: Administrator, office manager, or designee Date of completion 8/24/14. *** The remaining resident fund balance for resident number 70 was paid toward the	08/24/2014			

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F000253 SS=D	<p>indicated she spoke with family member's of Resident #70 two weeks ago about the balance owed to the facility and indicated the family understood the resident had a balance owed to the facility. The family member informed the facility that Resident #70 had no other funds. The Office Manager indicated at the time of speaking with the family member, she was unaware there was money in the trust fund and did not speak with family member's concerning the balance in the resident's trust fund. The Office Manager indicated she assumed the facility would keep the balance for monies owed for room and board. As of 7/25/2014 at 10:25 a.m., the Office Manager indicated the funds were still in the resident's trust account.</p> <p>3.1-6(h)</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and</p>		remaining balance for co-insurance owed by resident number 70 at time of death, as was requested by the family.		

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	<p>maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to provide an odor free environment for 2 residents out of a census of 63 Residents. (Residents #3 and #52)</p> <p>Finding includes:</p> <p>On 7/21/2014 at 3:15 p.m., Room 214 was observed to have a urine odor. A urinal, with urine in it, sat on the dresser of Resident #52.</p> <p>On 7/22/2014 at 9:45 a.m., Room 214 was observed to have a urine odor. There was a urinal with urine in it sitting on the dresser next to the bed of Resident #52. There was also a urinal with urine in it on the bedside table of Resident #3</p> <p>On 7/22/2014 at 10:55 a.m., Room 214 was observed to have urine odor. Urinals remain in the same location and continue to have urine in them.</p> <p>On 7/23/2014 at 11:30 a.m., Room 214 was observed to have a urine odor.</p> <p>On 7/24/2014 at 2:45 p.m., Room 214 was observed to have a urine odor and a urinal sitting on the bedside table of Resident #3</p>	F000253	<p>F253- Residents #3 and #52 will have an odor free environment by resident's urinals being emptied every 2 hours on rounds and as needed. C.N.A. will make rounds on resident's rooms to assure that urinals are emptied on a timely basis. Staff will be inserviced on the importance of assuring that urinals are being emptied on a timely basis and new urinals will be will be distributed weekly. Unit manager or designee will monitor by doing rounds that urinals are emptied, this will be monitored daily for for 2 weeks then weekly random spot checks will be conducted indefinitely. The "Unit Rounds QA tool will be utilized for this. In addition to this the DON will attempt to locate some sort of urinal cover for resident to put urinal in so it is not out in clear view.</p> <p>Any problems identified will be corrected immediately The results of the QA audits will be reviewed at the monthly QA meeting and any recommendations made will be followed.</p> <p>Person responsible: DON or designee</p>	08/24/2014

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F000279 SS=D	<p>On 7/25/2104 at 1:15 p.m., during an interview, Resident # 52 indicated the staff tries to do a good job keeping his urinal emptied. Resident #52 indicated he didn't want to complain.</p> <p>On 7/25/2014 at 1:20 p.m., during an interview, the PTA (Physical Therapist Assistant) #27 indicated he did not smell a urine odor in the hallway but did smell urine when he crossed the threshold into room 214.</p> <p>3.1-19(f)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services</p>			

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	<p>that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to develop a comprehensive care plan related to bruising for 1 of 1 residents reviewed for bruising. (Resident #31)</p> <p>Finding includes:</p> <p>On 7/21/2014 at 10:42 a.m., Resident #31 was observed to have several quarter size dark purple bruises on her left forearm.</p> <p>The clinical record for Resident #31 was reviewed on 7/23/14 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes, general osteoarthritis involving multiples sites, anxiety, and chronic kidney disease stage 4.</p> <p>Resident #31's weekly nursing assessments, dated 7/18/2014, 7/11/2014, 7/4/2014, 6/20/2014 and 6/13/2014, indicated no bruising.</p> <p>Resident #31's chart lacked documentation of Resident #31 having several bruises on left forearm, and</p>	F000279	F279- Bruising to resident #31 not identified on the comprehensive care plan. Bruising or other items are noted on a resident during weekly head to toe assessments by a licensed nurse. The C.N.A.'s will utilize a "shower tool" with a diagram of a body on it for each and every shower or complete bed bath given. This will be turned in to the charge nurse by the end of each shift. Further investigation of the bruising will take place by the nurse doing a thorough assessment. The family and the physician will be notified and the areas will be assessed per policy &/or physicians order. A comprehensive care plan will be implemented within the shift of finding the injury. The assessment noting a new bruise or injury will flag on the "Dashboard" page of the Electronic Medical Record and be reviewed by DON, ADON, MDS Coordinator and other nurses. It will be checked daily followed by a check of the care plan. If a care plan has not been implemented the nurse that was responsible	08/24/2014

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	<p>lacked documentation of skin care plan.</p> <p>Resident #31 MAR (Medication Administration Record) indicated that Resident #31 has an order for Atarax (acts as an antihistamine) 25 mg (milligrams) one tab every 8 hrs (hours) PRN (as needed) for itching.</p> <p>During an interview on 7/24/2014 at 2:02 p.m., the ADON (Assistant Director of Nursing) indicated the bruising is from Resident #31 scratching, itching and picking at her arm. The ADON indicated that the nurses were not charting the bruising on there weekly nursing assessments, the nurses were not looking at it as a bruise. The ADON indicated it was on going with Resident #31's skin. The ADON indicated we did not have a care plan for Resident #31's bruises.</p> <p>During an interview on 7/24/2014 at 2:10 p.m., LPN #21 indicated Resident #31 always has bruises on her arms, I don't chart it in the nursing assessments.</p> <p>During an interview on 7/24/14 at 3:25 p.m., the DON (Director of Nursing) indicated we do not have a care plan in place for Resident #31 bruises. The DON indicated the bruising was from Resident #31 itching and picking at her arms. The DON indicated we have</p>		<p>will be notified to put it in the EMR. If that nurse is unavailable the DON or Designee will implement the care plan then inform the nurse. This will be checked daily Monday through Friday and randomly on the weekends indefinitely. A checklist as a QA tool has been developed to track this. Any problems found will be corrected immediately. Re-education and 1 on 1 reviews with the nurses will be done as needed. Person responsible: DON or designee</p>	

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F000282 SS=E	utilized the PRN Atarax, the resident has not asked for it. 3.1-35(a)(1) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to follow care plans related to the use of Z-boots or pain assessments for 3 of 3 resident's reviewed for care plans. (Resident #19, #63, #56).	F000282	F282- F282- Resident # 19 will have her Z-boots on at all times except for bathing for pressure relief to heels. Resident #63 and #56 will be assessed using the pain scale before administration of medication and after administration for the	08/24/2014			

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	<p>Findings include:</p> <p>1. The clinical record for Resident #19 was reviewed on 7/24/14 at 8:21 a.m. The diagnoses included, but were not limited to, unspecified debility, hypertension chronic kidney disease, anorexia, osteoporosis and wound on right heel.</p> <p>A Skin Risk Care Plan for potential for skin breakdown was in Resident #19's clinical record. The interventions included the following: Z-boots (eliminates pressure on the heel for treatment and prevention of heel pressure ulcers) on at all times except bathing.</p> <p>During an observation on 7/23/2014 at 11:00 a.m., Resident #19's Z-boots were observed lying in broda chair. Resident #19 was observed lying in bed.</p> <p>During an observation on 7/24/2014 at 9:33 a.m., Resident #19's Z-boots were observed lying in broda chair. Resident #19 was observed lying in bed.</p> <p>During an interview on 7/24/2014 at 9:42 a.m., RN #2 indicated the Z-boots were to be on at all times.</p> <p>2. The clinical record for Resident #63</p>		<p>effectiveness of medication. There were not any negative outcomes from this practice. All residents have the potential to be affected by these practices.***All residents were checked to ensure that any interventions on the careplan were put into place. A report from electronic medical records that lists all interventions was utilized. This type of audit will be used for future monitoring also. No other residents were found to be affected. Staff will be inserviced on the importance of following plan of care of the resident, assessing pain using the pain scale including the importance of documenting using the pain scale and not just words such as "effective", and the placement as ordered for special equipment. The charge nurses will check every shift for the placement of special equipment, including but not limited to the Z-boots. The charge nurse will immediately correct any non-compliance as able. The C.N.A. assignment sheets will be updated to indicate any special equipment to be placed on a resident and when it should be done as it is stated on plan of care. Unit manager or designee will monitor completion of the use of the pain scale before and after administration of pain medications and the monitoring of special equipment being in place 5 days a week for 2 weeks, then weekly for 6 weeks followed by</p>		

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	<p>was reviewed on 7/23/2014 at 9:22 a.m. The diagnoses included, but were not limited to, acute but ill defined CVA (cerebral vascular accident), depression disorder, anxiety, osteoporosis and generalized pain.</p> <p>A Pain Care Plan was noted in Resident #63's clinical record. The interventions included to assess pain using 0-10 scale and to monitor the effectiveness of the pain medication.</p> <p>Resident #63 MAR (Medication Administration Record) was reviewed on 7/23/2014 at 11:49 a.m. RN #2 indicated, at this time, that Resident #63 takes Tramadol 50mg (milligram) one tab po (by mouth) every 6 hrs (hours) PRN (as needed) for moderate pain. RN #2 indicated that so far for the month of July Resident #63 has only received two doses of the PRN Tramadol. On 7/16/2014 PRN Tramadol was given to Resident #63 there was no documentation of the pain scale being used, LPN #21 documented the medication was effective but the pain scale was not noted on the PRN sheet. On 7/23/2014, RN #2 indicated I gave Resident #63 her PRN Tramadol, but forgot to write it on the back of the PRN sheet. RN #2 wrote the date, time and medication she gave on the back of the PRN sheet no documentation</p>		<p>monthly thereafter. The results of the QA audits will be reviewed by the monthly Quality Assurance Committee and any recommendations will be followed. Person responsible: DON or designee All residents receiving PRN pain medication were audited to ensure the pain scale is being used. QA audit tool created to interview residents for effectiveness of pain management.</p>				

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	<p>of the pain scale was noted.</p> <p>During and interview on 7/24/14 at 12:15 p.m., the DON (Director of Nursing) indicated the nurses should document the medication and assessment required before and after administration of medication on the PRN sheet as soon as they give the PRN medication.</p> <p>3. The clinical record for Resident #56 was reviewed on 7/25/2014 at 2:46 p.m. The diagnoses included, but were not limited to, chronic pain, muscular wasting polyneuropathy in diabetes, depressive disorder, unspecified psychosis, insomnia unspecified.</p> <p>The resident's care plan indicated potential for pain/discomfort immobility, pressure points resident has chronic back pain, neuropathy, muscle spasms, arthritis and chest wall pain. The goal was indicated for pain to be controlled to an acceptable level. The interventions included, but were not limited to, assess pain using the 0-10 scale, monitor the effectiveness of pain medications, reposition as needed for comfort and notify nurse of complaints.</p> <p>A pain scale assessment for (PRN) as needed medications, dated on 7/10/14 at 4 a.m. and 7/13/14 at 9 a.m., indicated</p>						

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F000309 SS=D	<p>medications were administered by mouth with documentation of back pain and no pain scale assessment noted.</p> <p>During an interview on 7/24/14 at 12:15 p.m., the DON indicated staff should document the medication administered and the assessment required for administration of medication on the PRN sheet at time of administration.</p> <p>On 7/24/2014 at 8:45 a.m, the ADON (Assistant Director of Nursing) provided the current Medication Administration Policy and Procedure, dated 10/04/2012. Titled "Administering Oral Medications" 17. "Complete necessary assessments before administering medications." 23. "Document initials on the administration record and any other assessment/information needed...."</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. Based on observation, interview and</p>	F000309	F309- Resident #23 did not have any negative outcomes from	08/24/2014			

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	<p>record review, the facility failed to ensure the identification and assessment of several bruises for 1 of 1 resident reviewed with several bruises (Resident #31) and failed to ensure an neurological assessment was completed for 1 of 1 resident reviewed for neurological assessment. (Resident #23).</p> <p>Findings include:</p> <p>1. On 7/21/2014 at 10:42 a.m., Resident #31 was observed to have several quarter size dark purple bruises on her left forearm.</p> <p>The clinical record for Resident #31 was reviewed on 7/23/14 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes, general osteoarthritis involving multiples sites, anxiety, and chronic kidney disease stage 4. Resident #31's weekly nursing assessments, dated 7/18/2014, 7/11/2014, 7/4/2014, 6/20/2014 and 6/13/2014, indicated no bruising.</p> <p>Resident #31's chart lacked documentation of Resident #31 having several bruises on left forearm and lacked documentation of skin care plan.</p> <p>Resident #31 MAR (Medication Administration Record) indicated that</p>		<p>the incomplete documentation of neurological checks. Resident # 31 did not have any negative outcome as a result of the bruising being documented or assessed as bruises. No other residents were found to be affected by these practices. Every resident will have a complete head to toe assessment upon admission, weekly and as needed at any time by a licensed nurse, this will be documented in proper assessment The C N A's will utilize a "shower tool" with a diagram of a body on it for each and every shower or completed bed bath given. This will be turned in to the charge nurse by the end of each shift. Further investigation of any skin issues or bruising will take place by the nurse by doing a thorough assessment. The family and the physician will be notified and the areas will be assessed per policy &/or physicians order. A comprehensive care plan will be implemented within the shift of finding the injury. The assessment noting a new bruise or injury will flag on the "Dashboard" page of the Electronic Medical Record and be reviewed by DON, ADON, MDS Coordinator and other nurses. It will be checked daily followed by a check of the care plan. If a care plan has not been implemented the nurse that was responsible will be notified to put it in the</p>				

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	<p>Resident #31 has an order for Atarax (acts as an antihistamine) 25 mg (milligrams) one tab every 8 hrs (hours) PRN (as needed) for itching.</p> <p>During an interview on 7/24/2014 at 2:02 p.m., the ADON (Assistant Director of Nursing) indicated the bruising is from Resident #31 scratching, itching and picking at her arm. The ADON indicated that the nurses were not charting the bruising on there weekly nursing assessments, the nurses were not looking at it as a bruise. The ADON indicated it was on going with Resident #31's skin. The ADON indicated we did not have a care plan for Resident #31's bruises.</p> <p>During an interview on 7/24/2014 at 2:10 p.m., LPN #21 indicated Resident #31 always has bruises on her arms, I don't chart it in the nursing assessments.</p> <p>During an interview on 7/24/14 at 3:25 p.m., the DON (Director of Nursing) indicated we did not have a care plan in place for Resident #31 bruises. The DON indicated the bruising is from Resident #31 itching and picking at her arms. The DON indicated we have utilized the PRN Atarax, the resident has not asked for it.</p> <p>2. The clinical record for Resident #23 was reviewed on 7/22/2014 at 3:28 p.m.</p>		<p>EMR. If that nurse is unavailable the DON or Designee will implement the care plan then inform the nurse. This will be checked daily Monday through Friday and randomly on the weekends indefinitely. A checklist as a QA tool has been developed to track this. Any problems found will be corrected immediately. Re-education and 1 on 1 review with the nurses will be done as needed. Any resident that has a fall that is not witnessed or hits their head will have neuro checks implemented as per policy unless it is discontinued by the physician. Unit manager or designee will monitor the completion of the neurological assessment 5 days a week for a period of 12 months. The completed neurological forms will be turned into the DON or designee. An additional audit will be conducted at that time. If there is a lack of assessment for any of the specified time frames the nurse responsible will be contacted for completion, re-education or disciplinary action whichever may be the appropriate measure. This will be done with each and every neurological assessment. The results of the QA audits will be reviewed by the monthly Quality Assurance Committee and any recommendations will be followed. Person responsible DON or Designee</p>				

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	<p>The diagnoses included, but were not limited dementia with behavioral disturbances, osteoporosis, psychotic with hallucinations and abnormal gait.</p> <p>An Incident report, dated 7/1/14, indicated Resident #23 was sitting at the South hall nurses station. Resident #23 had previously been up and ambulated via staff. Resident #23 was visiting with others, stood to ambulate and lost balance falling and hitting head on china cabinet and right side on porcelain tile.</p> <p>An Neurological Checklist was reviewed on 7/22/2014 at 1:25 p.m., indicated the following: Assess every 15 minutes x 1 hour, then every 30 minutes x 2 hours, then every 2 hours x 12 hours, then every 4 hours x 12 hours, then every 8 hours x 3 days, then daily x 4 days.</p> <p>Resident #23 neurological checks were started the following was noted: On 7/1/2014 neurological checks were documented at 4:30 p.m., 4:45 p.m., and 5:00 p.m., from 5:15 p.m., to 7:15 p.m., documented Resident #23 was at hospital. Resident #23 returned from hospital neurological checks were documented at 9:15 p.m., and 11:15 p.m. On 7/2/2014 neurological checks were documented at 1:15 a.m., 3:15 a.m., 5:15 a.m., 7:15 a.m., 11:15 a.m., 3:15 p.m.,</p>						

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	<p>and 7:15 p.m. On 7/3/2014 neurological checks were documented at 3:15 a.m. and 7:15 p.m. On 7/4/2014 neurological checks were documented at 3:15 a.m. and 7:15 p.m. On 7/5/2014 neurological checks were documented at 3:15 a.m. and 11:15 a.m. On 7/6/2014 through 7/9/2014 no further neurological checks were documented.</p> <p>During an interview on 7/24/2014 at 9:02 a.m., the DON (Director of Nursing) indicated we did not have an order from the physician to stop the neurological checks. The nurses had just quit doing them.</p> <p>On 7/23/2014 at 9:19 a.m., the DON provided the current Neurological Assessment Policy and Procedure, dated 3/11/2009. The policy and procedure indicated, 1. "PURPOSE To promptly identify changes in a resident's neurological status which may indicate increased intracranial pressure. 2. PROCEDURE A. Neurological checks must be done whenever head injury is suspected. D. Assess resident using the neurological checklist for a total of 7 days. (See below). E. Document assessment on neurological checklist form using the following schedule: I. Once every 15 minutes for the first hour, then once every 30 minutes for the next 2</p>						

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F000353 SS=F	<p>hours, then every 2 hours for the next 12 hours, and then every 4 hours for the next 12 hours then 8 hours x 3 days then daily x 4 days. 3. WHAT TO ASSESS A. Level of Consciousness: B. Function of Cranial Nerves: C. Pupil Responses. D. Check Breathing. E. Vital signs must be checked with every neurological assessment...."</p> <p>3.1-37(a)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on record review and interview, the facility failed to provide sufficient</p>	F000353	F353- Residents #32, #56, #26, #43, #64, #74, #38 and # 82 Waiting too long for call light to be	08/24/2014	

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	<p>staffing to meet the needs of the residents, related to waiting long periods of time for help. This affected 8 of 11 residents interviewed regarding staffing (Residents #32, #56, #26, #43, #64, #74, #38, #82) and had the potential to affect all 63 residents residing in the facility.</p> <p>Finding includes:</p> <p>During an interview, on 7/21/14 at 10:07 a.m., Resident #32 indicated the call light waiting time was long and she has had to wait up to two hours to go to the bathroom. The waiting length was worst at bed time.</p> <p>During an interview, on 7/21/14 at 10:34 a.m., Resident #56 indicated the call light waiting time was long, and he has had to wait up to 20 minutes for someone to respond.</p> <p>During an interview, on 7/21/14 at 11:05 a.m., Resident #26 indicated she has had to help her roommate with her needs, due to call light times being so long. The call light times were worse during meals and night shift. Her roommate has had to wait 30 minutes or longer for assistance from staff.</p> <p>During an interview, on 7/21/2014 at 11:21:49 a.m., Resident #43's brother</p>		<p>answered. There have not been any negative outcomes related to this practice. All residents have the potential to be affected by this practice. No other residents were found to be affected by this practice. *** All other residents that were not cited in the 2567 were interviewed regarding call light response time utilizing the QA tool "Call light response audit" No other residents were identified as having a concern. An increase of a minimum of 8 hours per day has been approved by the COO, CFO, Regional Vice President and the Vice President of Quality Assurance for direct care staff (C.N.A.'s or any qualified staff). Also the reallocation of hours from some administrative hours to direct care staff has been done. Third shift will increase by one staff member. Flexing shift hours will allow overlap coverage from one shift to next as needed. An additional C.N.A. will be added to overlap the day and evening shifts. The residents, families and staff will be interviewed and evaluated weekly by the Administrator, DON, Social Service Director and/or designees to ensure that the needs of the residents are met. and employee satisfaction is good. If any deficiencies discovered in any of these areas the staffing patterns and allocation of hours will be re-evaluated and restructured to further meet the highest practical</p>				

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	<p>indicated six months ago his brother had went to the desk and told them he needed help, after no one came he tried to do it himself and had a mess. When bringing his brother back from an outing on the weekends, he has noticed there was very few staff to help.</p> <p>During an interview, on 7/21/14 at 11:23 a.m., Resident #64 indicated the aide's on first and night shift do not have enough help. She has had to wait long periods of 15 to 20 minutes for her call light to be answered.</p> <p>During an interview, on 7/23/14 at 11:12 a.m., Staff #5 indicated some days there was not enough staff. The resident's have had to wait longer on the days that staff call off work. This was a frequent occurrence when CNA's (certified nurse assistant) work short handed.</p> <p>During an interview, on 7/23/14 at 11:14 a.m., Staff #6 indicated there was not enough CNA's for her to do her job in a timely manner. In the morning and after meals residents require toileting and there were normally three CNA's per hall. There were several occurrences that staff call in and they have had to work with only two CNA's on one of the assigned halls.</p>		<p>physical, mental and psychosocial well-being in accordance with comprehensive assessment and plan of care. Call light response time will continue to be monitored daily utilizing the QA tool. The DON or designee is responsible. The results of the QA audits will be reviewed by the monthly Quality Assurance Committee and any recommendations will be followed. The Director of Nursing will ask to be invited to the next Resident's Council Meeting to discuss the staffing concerns, call light response time. She will also explain the changes and improvements that have been implemented and take into consideration any suggestions they might have. The nursing department or Administrator will then attend any resident council meetings or provide any written response as requested in the future. This will be an ongoing practice of the facility. . Person responsible: administrator, DON or designee. We respectfully request that F 353 be deleted from 2567 regarding the survey completed on 7/25/2014. We will explain how this information was inaccurate, incomplete and unfair. The surveyors only requested time (hours) of HOURLY staff that utilize a time card. They went solely by hours on the punch detail which omitted many others hours of administrative staff,</p>		

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	<p>During an interview, on 7/23/14 at 11:43 a.m., Staff #7 indicated some days there was not enough staff to answer call lights without residents having to wait for long periods. She indicated that it was the worst when CNA's work short handed, which happens frequently.</p> <p>During an interview, on 7/23/14 at 11:55 a.m. The DON (Director of Nursing) and ADON (Assistant Director of Nursing) indicated the manner in which they replace call in's was to "Call everyone of the PRN (as needed) employees and if the position cannot be filled they will work the floor." They indicated there was not a specific policy and procedure for staffing. They indicated, "we staff to meet the needs of the residents." The DON indicated there were no issues with frequent call in's.</p> <p>During an interview, on 7/23/14 at 2:01 p.m., Staff #8 indicated on the North Hall they have three hooyer lift residents. There were eleven other residents whom require two assistance with ADL (Activities of Daily Living). There were times when the CNA's do not have enough staff to give good care.</p> <p>During an interview, on 7/23/14 at 2:22 p.m., Staff #9 indicated residents appear impatient during meal times when they</p>		<p>medical records, D.O.N., A.D.O.N., MDS Coordinator and Administrator who is also a C.N.A along with some other nurses. These additional staff members are utilized to assist with all meals, the nurses work on the floor as needed. A tremendous amount of effort and focus has been put forth the last several months to improve call light response time. This is indicated in the monthly resident council minutes and the monthly QAA minutes. The QA committee has been pleased with the progress in this area. The facility was not aware the surveyors believed the staffing was insufficient or we would have gladly produced more data to show that was not the case. The Unit Manager R.N. hours were staggered to cover half of the evening shift for resident care needs, call lights and whatever else may be necessary. The Administrative staff also rotates weekend "Manager on Duty" to have extra hands in the facility. The Nursing Administrative staff rotates the "on call" coverage for 24 hours/7 days a week. They make the phone calls to replace staff as needed and if no one is willing to come in they come in and work shifts to meet the needs of the residents. In addition to all of this there is B.N.A. and nursing students in the building that render care during their hours of clinicals. The residents have</p>				

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	<p>have to wait to be toileted. The residents have to wait longer then normal for their call lights to be answered.</p> <p>During an interview, on 7/24/14 at 9:13 a.m., Staff #10 indicated on the South Hall, there were five residents whom require the use of a hoier lift and six to seven other residents whom require extensive two personal assistance. The residents are having to wait often due to all the call in's.</p> <p>During an interview, on 7/24/14 at 10:46 a.m., Resident #74 indicated current CNA's need more help, "The workers would be more willing to work if they had back up and were not so stressed to cover all the residents needs."</p> <p>During an interview, on 7/24/14 at 2:42 p.m., Resident #38 indicated there was not enough staff in the morning and after meals. She worries about accidents due to long wait times for assistance to use the toilet.</p> <p>During an interview, on 7/24/14 at 2:46 p.m., Staff #11 indicated sometimes there was not enough staff, this occurred due to a lot of call in's.</p> <p>During an interview, on 7/24/14 at 3:10 p.m., The ADON indicated all the S's</p>		<p>NEVER been left unattended or in any type of compromised situation. The meals times were also adjusted to better serve the residents. The C.N.A. assignments were also adjusted to improve efficiency. When there are the rare staffing needs the facility will implement bonus pay for those willing to work extra shifts in addition to any overtime that may be accrued. Each and every known concern from a family member, resident or staff has been addressed and all agreed that improvements have been made. The staff of Miller's Merry Manor and the company as a whole does take GREAT pride in the care we provide our residents. Unfortunately the residents that were cited are not always reliable in their information, if not confused or forgetful and 5 minutes can feel like "an hour" sometimes. Resident #26 cited as "indicating she had to help her roommate with her needs" at times is untrue. She had the "feeling" she was needed to help her roommate unnecessarily so that roommate was moved to alleviate this. Resident #26 cannot even take care of her own needs let alone take care of another. The 2567 states "residents #43's brother indicated 6 MONTHS AGO his brother went to the desk and told them he needed help, after no one came he tried to do it himself and had a mess"... 6 months</p>				

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	<p>marked on the calendar should be A's for Absent. No one has been suspended in the last year.</p> <p>During an interview, on 7/24/14 3:20 p.m., Resident #82 indicated she has to depend on her roommate to help with her needs. Her roommate helps since it takes a long time for girls to answer her call light and sometimes it takes over 30 minutes.</p> <p>Review of the attendance calendar sheets, provided by the ADON on 7/24/14, indicated 54 occurrences of CNA (certified nursing assistant) / BNA (basic nursing assistant) marked absent, dates from 1/6/14 to 7/21/14.</p> <p>3.1-17(a)</p>		<p>ago—many strides have been taken by the facility since then, unfair time frame. Also it says when bringing his brother back on weekends he has noticed there is very few staff to help. That could be his observation due to staff being in resident rooms providing care; offices being closed and less staff around, Therapy dept closed-again do not feel this is an accurate or fair statement. The staff interviews were partial statements or taken out of context. Staff and residents often think if they complain it will get them more staff. Unfortunately when all the administrative staff (as identified earlier) do work the floor providing direct care they are not perceived by staff or residents as being the direct care floor staff as it is not their normal roles. The staff will still view themselves as being "short staffed" when an administrative staff fills the empty slot even though they are taking a regular assignment and often completing the duties more efficiently than the regular staff. As in most LTC facility, restaurants, high traffic areas, schools or any place there are certain times of the day (and evening) that the demand is much greater with many more needing/wanting something at the same time. In addition to having additional hands on deck for meals there have been extra activities such as card club or music right after meals to occupy</p>		

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			<p>the residents while others are getting cared for. The bedtime routine is so that the residents can go to bed when they want to and is accommodating until someone changes their mind or there is an emergency. There was even an extra call light system board (alert) placed in the center of the facility so it could be heard by those that may be a ways down a hall or a nurse that is passing meds so that they could assist the residents as needed. The number of "call-ins" or abscesses cited as being 54 since January 2014. This works out to be 7.7 per month or average of 1 every 4 days which is average or below average in the industry. Several of the staff members that were cited in the 2567 are the staff that is the most frequently absent themselves! The facility does not, or never has left it with insufficient staff. This is also indicated by several other outcomes. 1) The residents are well cared for by general appearance. There are few to rare skin issues, few rapid declines even this often end of life stage. 2) The Quality Measures Composite score for the past year was 6 or less consistently. CMS recognized us for this OUTSTANDING ACHEIVEMENT. 3) The current Quality Measures as documented by the MDS and reviewed by the surveyors are well BELOW the State and National Average. This</p>		

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			<p>indicates excellent quality of care is provided to our residents. 4) The nursing staff turnover is ONLY 38%. This too is well below the average turnover rate indicating that employees are satisfied with their jobs. 5) The Human Resource Department conducts anonymous employee surveys. The last one was done in March of 2014. There was NOT a trend or high number of responses that the staff felt they worked with insufficient staffing ratios. 6) Abby-Press Ganey also conducted their resident, family and staff surveys. The results were good. There were NOT a high number of responses indicating they felt they were insufficiently staffed. 7) Risk Management Solutions-A national Consulting firm did an annual audit of the facility in May 2014. They found the facility to provide good care and had sufficient staffing. 8) The Corporate Quality Assurance Team did an annual Audit in April 2014. They did not cite insufficient staffing. 9) The daily staffing hours are posted for all to see and even the day before with hours as worked to show all there is sufficient staff. 10) The PPD (per patient day) year to date is 2.89. This does not include administrative staff, staff in orientation or training. It is sufficient for the census and acuity of the residents residing in the facility. 11) The Overtime percent is at or below corporate</p>		

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			average at 3-4% which also indicates sufficient staff. This shows that the staff can get their assignments completed timely. We will be glad to produce any of the documents mentioned above as proof of providing sufficient staff. While we are always striving for improvement and culture change the only thing we may be guilty of here is not pressing the issue that coverage is made in a variety of ways and that the awareness of call light response time is so heightened due to our weekly QA interviews and calls to families and residents. Again the responses have been positive. We also do adjust the PPD to whatever the current census is. Staff may perceive that as "being short staffed" despite explaining how this works and it may overflows to resident ears. The surveyors were very focused on the "negative" notation of questioning all for insufficient staff without gathering all of the information. They have a very difficult job and I am certain they feel they are making judgment calls in the best interest of the residents. In one sense this did work as we will be staffing at a higher rate to satisfy the concerns and compliance of F 353. However the real answer lies in the fact that the facility provides quality care to maintain the highest practical physical, mental, and psychosocial well-being of each resident, as determined by		

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with</p>		<p>resident assessments and individual plans of care. Again-low rates of skin issues, falls, infections, catheters, no concerns of abuse or neglect, pain is well controlled, psychoactive drugs have been greatly reduced, weight loss is low and usually for those with EXPECTED weight loss due to a disease process and no physical restraints. We appreciate your consideration in this dispute. Respectfully submitted, Carol Wilkins</p>		

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	<p>a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation record review and interview, the facility failed to ensure proper hand washing and proper use of equipment (scissors) during a clean dressing change for 2 of 2 residents reviewed. (Resident #19 and #34)</p> <p>Findings include:</p> <p>1. During a dressing change observation for Resident #19, on 7/24/14 at 9:33 a.m., RN #2 was observed to place wound supplies on the overbed table without placing a barrier on the table. RN #2 wash hands and placed disposable gloves on. RN #2 was observed to remove old dressing from right heel and place in Resident #19's trash can. RN #2 removed disposable gloves and placed in Resident #19's trash can did not wash hands. RN #2 put on new disposable gloves. RN #2 applied skin prep to both heels. RN #2 did not remove disposable</p>	F000441	<p>F441- Proper hand washing and use of equipment during dressing change on resident #19 and #34. There were not any negative outcomes to these residents by this practice. No other residents were found to be affected. *** The other residents in the facility that receive dressing changes resident numbers 55, 25, 2, and 28 were observed by DON and ADON for proper technique for handwashing and scissor cleaning when applicable, using the "Infection Control" QA tool. All residents have the potential to be affected by this practice. All licensed nurses will be in serviced on the proper hand washing techniques during dressing changes and cleansing of equipment during dressing changes. Each nurse will do a return demonstration. This will be a required skills check off process for every nurse upon hire, annually and as needed. Inservice Director or designee will do a weekly check X 8 weeks</p>	08/24/2014

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	<p>gloves or hand wash. RN #2 was observed to apply aquacell dressing to Resident #19's right heel. RN #2 removed disposable gloves placed them in Resident #19's trash can, applied Z-boots (eliminates pressure on the heel for treatment and prevention of heel pressure ulcers) on Resident #19's feet. RN #2 covered Resident #19 up and washed hands.</p> <p>2. During observation with RN #13 and RN #12 on 7/24/2014 at 1:52 p.m. RN #13 was performing wound care to the left and right heels of Resident #34. The scissors lying directly on the bed side table with no barrier on the table was used for the removal of the prior left heel bandage. The scissors were picked up by RN #13 and used to cut the soiled dressing off the right heel then she placed the scissors back on the bedside table. RN#12 picked up the scissors and cut the new sterile dressing in half. The scissors cut through the plastic covering and directly cut the dressing in half. The dressing was then placed directly on the right heel wound area by RN #13. The scissors were placed back on the bedside table. After completed the wound care, without cleansing the scissors RN #13 placed the scissors in her uniform pocket.</p> <p>RN #13 removed her gloves following the soiled dressing removal on Resident</p>		<p>during a dressing change to assure proper technique is used. This will then be done monthly indefinitely. Any deficient practice will be corrected immediately followed by re-education or disciplinary action as deemed appropriate. The results of the skills checks and observations will be reviewed by the monthly Quality Assurance Committee and any recommendations will be followed. person responsible: DON or designee</p>				

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	<p>#34's right heel and replaced her gloves without washing hands in between. She then used her bare hand to help push the fingers down on the gloved hand. After placing on both gloves she placed a clean dressing on Resident #34's right heel.</p> <p>The clinical record for Resident #34 was reviewed on 7/24/14 at 2:00 p.m., and indicated culture of the left heel wound results were Methicillin Resistant Staphylococcus Aures (MRSA).</p> <p>During an observation on 7/24/14 at 1:52 p.m., Resident #34 had a stop sign on the side of the entry door to his room.</p> <p>During an interview on 7/24/2014 at 1:52 p.m., RN #13 indicated Resident #34 was in contact isolation for Methicillin Resistant Staphylococcus Aures.</p> <p>On 7/24/14 at 10:30 a.m., the DON (Director of Nursing) presented a copy of the facility's current policy and procedure for "Dressing-Clean Procedure. C. Procedure:... 3. Wash hands thoroughly. 4. Place treatment chux, clean towel, or papertoweling on overbed table and treatment chux or protective liner under resident's wound area. 6. Apply gloves. 7. Remove soiled dressings and discard in plastic bag, including gloves. 8. Wash hands. 9. Apply clean gloves and cleanse</p>						

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F009999	<p>wound with prescribed solution. Discard gloves in plastic bag. Wash hands. 10. Apply clean gloves, apply medication, if prescribed, apply dressing and secure with tape. 11. Remove treatment changed under wound area and discard with soiled dressing, disposable equipment, and gloves in plastic bag. Tie off bag. 12. Wash hands. (NOTE): Gloves should be changed and hands washed after removing dirty dressing, cleansing wound and applying medication and dressing."</p> <p>3.1-18(l) 3.1-18(b)(2)</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department -approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. the result shall be recorded</p>	F009999	F-9999 The facility will ensure employees have proper screening for TB. This screening will occur on/before the actual annual due date of the prior years screening. Nursing management will audit every employee file and use a running list to be sure all screenings are timely. 1.) Housekeeper #1 TB test was negative. She has been put on a schedule to receive her next annual TB on or before the same date for 2015. 2.) A new system has been put into place for all employees to be placed on a schedule that will repeat the test on or before their annual date, not	08/24/2014			

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	<p>in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) month, the baseline tuberculin skin test should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure employees had proper screening for tuberculosis (TB). This effected one of ten employee files reviewed. (Housekeeper #1)</p> <p>Finding includes:</p>		<p>just in the month it is due. All were checked for dates with an annual time frame and will be correct with plan of correction date. The inservice director is aware of this procedure and will educate all staff upon hire and when PPD is administered. The employee PPD list will be audited monthly with dates due to be posted for all employees. The office manager will complete a 2nd audit to check the timeframe for PPD's. Any non-compliance will be corrected immediately and the employee will not be allowed to work until in compliance. Inservice director or designee are responsible for this procedure. The administrator will report all unusual occurrences to the SBOH with in 24 hours of occurrence. All residents have the potential to be affected. As identified by daily and weekly observance/assessment, Bruises above 10 cm will be reported when measured as such even if smaller at time of occurrence. when the hemotoma increase in size over time, that injury will be reported if it reaches/exceeds 10cm in size 1.) Resident #23 hemotoma is resolved. There were no negative outcomes due to this practice. 2.)All current residents with any bruising or injuries have been observed and any documented greater than 10 cm in size reported to ISDH. 3.) All nursing staff, DON, and Administrator have been</p>				

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	<p>On 7/24/2014 at 12:05 p.m., the employee file for housekeeper #1 was reviewed and was found that her last annual TB screening was administered on 7/15/2013.</p> <p>On 7/24/2014 at 12:20 p.m., the ADON (assistant director of nursing) indicated the employees get their annual TB screening the month they are due not by the actual due date.</p> <p>On 7/24/2014 at 12:28 p.m., the ADON provided a copy of the facility's current policy for "Employee Health - TB Screening."... "The frequency of repeat tuberculin skin testing will depend on the risk of infection with tuberculosis, but no less than annually thereafter...."</p> <p>3.1-14(t)(1)</p>		<p>in-serviced on the policy for reporting unusual occurrences 4.) The DON or designee will review the documentation of all injuries for the 1st 72 hours. This will be done by using the electronic medical record. An ongoing log for all injuries will be maintained by DON or designee. The results of the employee PPD audits and the reportable injury audits will be reviewed at the monthly QA meeting. any recommendations will be followed. Person responsible: Administrator, DON or designee</p>		