

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155297	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S HEALTH & REHAB BY MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350
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F000000	<p>This visit was for the Investigation of Complaint IN00155220.</p> <p>Complaint IN00155220- Substantiated. Federal/State deficiencies related to the allegations are cited at F-157, F-281, F-282, F-498, and F-514.</p> <p>Survey dates: September 17 & 18, 2014</p> <p>Facility number: 000194 Provider number: 155297 AIM number: 100267790</p> <p>Survey Team: Janet Adams, RN-TC</p> <p>Census bed type: SNF: 32 SNF/NF: 18 Total: 50</p> <p>Census payor type: Medicare: 26 Medicaid: 11 Other: 13 Total: 50</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings</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>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 23, 2014, by Janelyn Kulik, RN.</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 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</p>			

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	<p>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, record review, and interview, the facility failed to ensure the Physician was notified of eye drops not given and the need to clarify orders for 2 of 4 residents reviewed for Physician notification in the sample of 4. (Residents #D and #G)</p> <p>Findings include:</p> <p>1. The record for Resident #D was reviewed on 9/17/14 at 9:35 a.m. The resident's diagnoses included, but were not limited to, pneumonia, reflux esophagitis, high blood pressure, anemia, and dysphasia (difficulty swallowing).</p> <p>Review of the 8/2014 Medication Record indicated there was a Physician's order for the resident to receive Patanol (a medication for allergic eye inflammation) 0.1% ophthalmic (eye) drops. The order indicated the resident was to receive one eye drop to both eyes twice a day The medication was circled as not given on 8/13/14 through 8/19/14 at 9:00 a.m. The back of the Medication Record indicated an entry was made in the Nurse's</p>	F000157	<p>It is the policy of Miller's Merry Manor, La Porte to promptly inform the resident; consult with resident's physician, notify resident's legal representative or an interested family members when there is a significant condition change in the resident's physical, mental, or psychosocial status and or/the need to alter treatment significantly.</p> <p>Resident: D and G: Physician will be notified if resident has significant condition change in physical, mental, or psychosocial status and/or the need to alter treatment significantly such as clarifying an ordered medication or a medication not delivered as ordered by physician. Resident G physician was contacted on 9/18/14 to clarify calcium dose and new orders noted. Calcium will be administered as ordered by physician. Resident D eye drops will be administered as ordered by physician.</p> <p><i>All residents are at risk to be affected by the deficient practice.</i></p> <p>The nurse managers will complete an audit of all physician</p>	10/18/2014

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	<p>Medication Notes section on 8/17/14. This entry indicated the Patanol was unavailable and the Pharmacy was called and indicated the medication was last sent out on 8/2/14. There were no other entries related to the Patanol eye drops in August.</p> <p>The 8/2014 Nursing Progress Notes were reviewed. There was no documentation of the Physician being notified of medication not being administered from 8/13/14 through 8/19/14.</p> <p>The facility policy titled "Physician & Family Notification of Condition Change" was reviewed on 9/17/14 at 9:00 a.m. The policy had a start date of 3/1/2003. The Admission Nurse provided the policy and indicated the policy was current. The policy indicated the Physician was to be notified of any changes that may or may not warrant a change in the resident's treatment plan.</p> <p>When interviewed on 9/18/14 at 9:45 a.m., the Director of Nursing indicated the facility pre authorization for the medication and the Physician was called for that. The Director of Nursing indicated the Physician should have been notified the resident had not received the medication as ordered on the above dates.</p>		<p>orders by 10/18/14 to ensure resident specific orders are followed, available, clarified, and delivered per plan of care. An in-service with all licensed nursing staff will be held on or before 10/18/14 to review the facility policy for "Notification of Changes" and "Medication Pass Administration Procedure. Nurses will be responsible to document in the EMR any significant condition changes in resident's physical, mental, or psychosocial status and/or the need to alter treatment significantly.</p> <p>Licensed nurses will be instructed on the procedure to obtain ordered medication from the facility pyxis. If the medication is not available in the residents current stocked medications and is not available in the pyxis the facility charge nurse will contact the pharmacy to request that the needed item be delivered STAT to ensure timely administration of ordered medication or treatment. The charge nurse will be responsible to contact the MD in the event there is a delay in delivering medication/treatment as ordered in a timely manner. Any physician notification will also be documented in the EMR and on the 24 hour nursing report sheet. The nurse managers review the EMR and 24hour report daily to ensure significant changes in status are</p>				

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	<p>2. On 9/17/14 at 10:40 a.m., RN #1 was observed preparing medications for Resident #G. The RN opened two Calcium Citrate 200 milligram tablets. The RN indicated the resident was to receive two of the Calcium tablets. The RN checked the medications against the Medication Record. The Medication Record indicated Calcium Citrate (no strength listed) one tablet daily was to be given at 9:00 a.m. The RN crossed out "one" and wrote "400 mg" on the Medication Record. RN #1 then prepared other oral medications and entered the resident's room. The RN administered two calcium pills to the resident.</p> <p>The record for Resident #G was reviewed on 9/17/14 at 3:28 p.m. The resident's diagnoses included, but were not limited to, arthropathy, Chron's disease (a gastrointestinal illness), and esophageal reflux. The resident was admitted to the facility on 9/12/14.</p> <p>Review of the 9/12/14 admission Physician orders indicated there was an order for the resident to receive Calcium Citrate one tablet by mouth daily. There were no other orders written related to the calcium medication to be given.</p> <p>The 9/2014 Nursing Progress Notes from</p>		<p>communicated to physician per policy. The DON or other designee will be responsible to complete the QA tool titled "24 Hour Condition Review" (Attachment A) daily x 1week, then bi-weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected and logged on facility QA tracking log. The unit manager or other designee will complete bi-weekly MAR/TAR auditsx4 weeks then weekly thereafter utilizing the QA tool "MAR/TAR Review" (Attachment B) to ensure that medications/treatments are being delivered as ordered by the physician. Any issues identified will be corrected upon discovery and logged on facility QA tracking log. The QA tracking logs are reviewed during the facility monthly QA meeting to ensure ongoing compliance.</p>				

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F000281 SS=D	<p>9/12/14 through 9/17/14 were reviewed. There was no verification in the Progress notes to indicate the Physician had been called to clarify the dosage on the calcium medication.</p> <p>When interviewed on 9/18/14 at 9:05 a.m., the Director of Nursing indicated the resident's Physician should have been notified of the need to clarify the dose. The Director of Nursing indicated the Physician had now been contacted and the dosage of the calcium was clarified to be 400 milligrams.</p> <p>This Federal tag relates to Complaint IN00155220.</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, record review and interview, the facility failed to ensure care was provided by qualified personal related to gastrostomy tube care for 1 of 3 residents reviewed for gastrostomy tubes in the sample of 4. (Resident #D) (CNA #2).</p>	F000281	It is the policy of Miller's Merry Manor, La Porte to provide and/or arrange for services that meet professional standards of quality. Resident #D: Gastrostomy tube care will only be provided by facility qualified nursing staff. Nurse aides will not be permitted to hold, stop, and start tube feeding pumps. Nurse aides will	10/18/2014

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	<p>Findings include:</p> <p>On 9/17/14 at 11:05 a.m., CNA #1 and CNA #2 were observed providing morning care for Resident #D. The resident was in bed. The resident had a gastrostomy tube (a tube placed into the stomach to provide feeding through) in place. A bag of Glucerna 1.2 tube feeding formula was hanging on a pole next to the resident's bed. The tube feeding was infusing via an infusion pump. The display on the pump noted the feeding was on hold. The CNA's bathed the resident and provided incontinence care. The infusion pump alarmed during care and CNA #2 pushed the hold button on the pump. The pump stopped alarming and the CNA's continued to change the resident's pad under her and then placed another pad to be used with a lift device under the resident. The CNA's then lifted Resident #D into her electric wheel chair in the room using a mechanical lift device. CNA #1 moved the tube feeding infusion pump closer to the resident. CNA #2 then turned the feeding on. There were no other staff members present when the CNA turned the tube feeding pump back on hold and then on after the resident was up in her electric wheelchair.</p> <p>The record for Resident #D was reviewed</p>		<p>be instructed to seek the licensed nurse for any needs to stop, start, or hold tube feedings. Both CNA's were immediately re-educated and instructed not to turn feeding pump on hold or to restart the feeding. All residents with a gastrostomy tube and receiving feedings via pump are at risk. Licensed nursing staff will provide all gastrostomy care for residents. On 9/17/14 the DON/ADM initiated re-training with all nursing staff regarding standards of practice and that only licensed nursing staff will operate a resident's tube feeding pump. All facility nursing staff will be educated on or before 10/18/14. Nurse aides participate in a 5day orientation upon hire, which will include education regarding scope of practice and that all gastrostomy care for residents is completed by licensed nurse. The nurse managers will make random walking rounds on all shifts to monitor and ensure that nurse aides do not turn pumps on hold, off, or on and that the charge nurses are requested by nurse aides for all gastrostomy care. Charge nurses receive an 11day orientation upon hire and will also be advised of the importance of monitoring nurse aide's work within scope of practice and that all gastrostomy care is to be completed by qualified nursing staff. The facility In-Service Director will be responsible to</p>		

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	<p>on 9/17/14 at 9:35 a.m. The resident's diagnoses included, but were not limited to, pneumonia, reflux esophagitis, high blood pressure, anemia, and dysphasia (difficulty swallowing). Review of the 9/2014 Physician Order Statement indicated there was a current Physician order for the resident to receive infusion of Glucerna tube feeding at 67 cc's (cubic centimeters) per hour. The tube feeding was to run from from 10:00 p.m. to 4:00 p.m. daily. There was also an order for the resident to be NPO (to receive nothing by mouth).</p> <p>Review of the 6/24/14 Minimum Data Set quarterly assessment indicated the resident's cognitive skills for daily decision making were moderately impaired. The assessment also indicated the resident was totally dependent on staff members for bed mobility, transfers, dressing, and personal hygiene.</p> <p>When interviewed on 9/17/14 at 11:30 a.m., CNA #2 indicated she had turned the pump back on hold during care as the feeding could not be infusing when the resident was flat in bed. The CNA also indicated she turned the pump on after the resident was placed in her wheelchair. The CNA indicated she had been turning the pump on hold and on during care before. CNA #2 indicated she was not not</p>		complete ongoing bi-annual education with nursing staff on facility policy/procedures for the care of gastrostomy tubes. The in-service director will complete the QA tool titled "Gastrostomy Tube Care/ Observation"(Attachment C) on all residents with gastrostomy tubes 3x weekly for 4weeks, then weekly x4 weeks then monthly thereafter to monitor ongoing compliance. Any issues identified will be promptly corrected and logged on facility QA log to be reviewed in the monthly Quality Assurance meeting.				

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	<p>told she could not turn the pump on and off.</p> <p>When interviewed on 9/17/14 at 2:20 p.m., the Nurse Consultant indicated the CNA Job Description and the Nurse Aide Training Program did not indicate the CNA's could turn tube feeding infusion pumps on and off. The Nurse Consultant indicated the CNA's should not be doing this.</p> <p>STANDARD 14. NURSE AIDE SCOPE OF PRACTICE http://www.in.gov/isdh/files/stand14_b.pdf.</p> <p>The nurse aide will perform only the tasks in the course standards and Resident Care Procedures manual, unless trained appropriately by licensed staff of the facility with policies and procedures and a system for ongoing monitoring to assure compliance with the task, i.e., (see supplements for examples). This additional training would only apply for tasks, which are not prohibited by paragraphs 2 and 3 of this section and by current rule, which prohibits the giving of injections.</p> <p>The nurse aide will not perform any invasive procedures, including enemas and rectal temperatures, checking for and/or removing fecal</p>						

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F000282 SS=D	<p>impactions, instillation of any fluids, through any tubing, administering vaginal or rectal installations. The nurse aide will not administer any medications, perform treatment or apply or remove any dressings. Exception to the above would be the application of creams/ointments to intact skin, such as moisture barrier cream</p> <p>This Federal tag relates to Complaint IN00155220.</p> <p>3.1-35(g)(1)</p> <p>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 ensure the resident's plan of care was followed related a medication patch applied to the incorrect area for 1 of 4 residents reviewed for medications in the sample of 4. (Resident #E)</p> <p>Findings include:</p>	F000282	It is the policy of Miller's Merry Manor, La Porte that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care related to oral care, residents weight, pain management, insulin coverage, and antibiotic therapy.	10/18/2014			

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	<p>The closed record for Resident #E was reviewed on 9/17/14 at 10:05 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, stroke, high blood pressure, and a history of an ankle fracture.</p> <p>The 4/30/14 Minimum Data Set quarterly assessment indicated the resident's cognitive skills for daily decision making were severely impaired. The assessment also indicated the resident required extensive assist (resident involved in activity, staff provide weight-bearing support) of one staff member for bed mobility, dressing, and personal hygiene.</p> <p>Review of the 4/2014 Medication Record indicated there was a Physician's order for the resident to have a Lidocaine patch (a medicated patch to provide pain relief) applied topically to the right knee daily. The patch was to be applied at 9:00 a.m. daily and removed at 9:00 p.m. daily. The Lidocaine patch was signed out daily for the month of April.</p> <p>The 4/2014 Nursing Progress Notes were reviewed. An entry made on 4/4/14 indicated "This nurse put pt's (patient) Lidocaine patch on her left knee instead of her right knee for the last two days."</p>		<p>Resident E: Has been discharged from the facility</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>The nurse managers will complete an audit of all physician orders by 10/18/14 to ensure orders are followed, available, and delivered as ordered by physician. The facility policy for "Medication Pass Procedure", "Notification of Changes", and "Pertinent Charting Guidelines" will be reviewed. The importance of placing medication patches on the area indicated in the physicians order will be emphasized and the nurse will document the location patch is applied with each administration.</p> <p>The unit manager or other designee will be responsible to complete a "MAR/TAR Review" (Attachment B) biweekly x4 weeks, then weekly thereafter to monitor for ongoing compliance. Any identified trends will be corrected upon discovery and documented on facility QA tracking log. The In-Service Director or other designee will be responsible to complete a "Medication Administration Observation" with all newly hired charge nurses and on all nurses quarterly to monitor for ongoing compliance. Any findings will be recorded on a facility QA log and</p>				

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F000498 SS=D	<p>When interviewed on 9/18/14 at 9:05 a.m., the Director of Nursing indicated the resident's patch should have been applied to the right knee as ordered.</p> <p>This Federal tag relates to Complaint IN00155220.</p> <p>3.1-35(g)(2)</p> <p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure CNA's did not render only resident care procedures per their job description related to turning gastrostomy feeding tube infusion pumps on on and off during care for 1 of 3 residents reviewed for PEG tube care in the sample of 4. (Resident #D) (CNA #2)</p> <p>Findings include:</p> <p>1. On 9/17/14 at 11:05 a.m., CNA #1 and CNA #2 were observed providing</p>	F000498	<p>the DON or other designee will be responsible to provide ongoing education as needed on an individual basis for any identified documentation issues to ensure compliance. QA logs are reviewed monthly during QA meeting to monitor ongoing compliance.</p> <p>It is the policy of Miller's Merry Manor, La Porte to provide and/or arrange for services that meet professional standards of quality.</p> <p>Resident #D: Gastrostomy tube care will only be provided by facility qualified nursing staff. Nurse aides will not be permitted to hold, stop, and start tube feeding pumps. Nurse aides will be instructed to seek the licensed nurse for any needs to stop, start, or hold tube feedings. Both CNA's were immediately re-educated and instructed not to turn feeding pump on hold or to</p>	10/18/2014

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	<p>morning care for Resident #D. The resident was in bed. The resident had a gastrostomy tube (a tube placed into the stomach to provide feeding through) in place. A bag of Glucerna 1.2 tube feeding formula was hanging on a pole next to the resident's bed. The tube feeding was infusing via an infusion pump. The display on the pump noted the feeding was on hold. The CNA's bathed the resident and provided incontinence care. The infusion pump alarmed during care and CNA #2 pushed the hold button on the pump. The pump stopped alarming and the CNA's continued to change the resident's pad under her and then placed another pad to be used with a lift device under the resident. The CNA's then lifted Resident #D into her electric wheel chair in the room using a mechanical lift device. CNA #1 moved the tube feeding infusion pump closer to the resident. CNA #2 then turned the feeding on. There were no other staff members present when the CNA turned the tube feeding pump back on hold and then on after the resident was up in her electric wheelchair.</p> <p>The record for Resident #D was reviewed on 9/17/14 at 9:35 a.m. The resident's diagnoses included, but were not limited to, pneumonia, reflux esophagitis, high blood pressure, anemia, and dysphasia</p>		<p>restart the feeding.</p> <p>All residents with a gastrostomy tube and receiving feedings via pump are at risk.</p> <p>Licensed nursing staff will provide all gastrostomy care for residents. On 9/17/14 the DON/ADM initiated re-training with all nursing staff regarding standards of practice and that only licensed nursing staff will operate a resident's tube feeding pump. All facility nursing staff will be educated on or before 10/18/14. Nurse aides participate in a 5day orientation upon hire, which will include education regarding scope of practice and that all gastrostomy care for residents is completed by licensed nurse. The nurse managers will make random walking rounds on all shifts to monitor and ensure that nurse aides do not turn pumps on hold, off, or on and that the charge nurses are requested by nurse aides for all gastrostomy care. Charge nurses receive an 11day orientation upon hire and will also be advised of the importance of monitoring nurse aide's work within scope of practice and that all gastrostomy care is to be completed by qualified nursing staff.</p> <p>The facility In-Service Director will be responsible to complete ongoing bi-annual education with nursing staff on facility</p>	

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	<p>(difficulty swallowing). Review of the 9/2014 Physician Order Statement indicated there was a current Physician order for the resident to receive infusion of Glucerna tube feeding at 67 cc's (cubic centimeters) per hour. The tube feeding was to run from from 10:00 p.m. to 4:00 p.m. daily. There was also an order for the resident to be NPO (to receive nothing by mouth).</p> <p>Review of the 6/24/14 Minimum Data Set quarterly assessment indicated the resident's cognitive skills for daily decision making were moderately impaired. The assessment also indicated the resident was totally dependent on staff members for bed mobility, transfers, dressing, and personal hygiene.</p> <p>When interviewed on 9/17/14 at 11:30 a.m., CNA #2 indicated she had turned the pump back on hold during care as the feeding could not be infusing when the resident was flat in bed. The CNA also indicated she turned the pump on after the resident was placed in her wheelchair. The CNA indicated she had been turning the pump on hold and on during care before. CNA #2 indicated she was not told she could not turn the pump on and off.</p> <p>When interviewed on 9/17/14 at 2:20</p>		<p>policy/procedures for the care of gastrostomy tubes. The in-service director will complete the QA tool titled "Gastrostomy Tube Care/Observation"(Attachment C) on all residents with gastrostomy tubes 3x weekly for 4weeks, then weekly x4 weeks, then monthly thereafter to monitor ongoing compliance. Any issues identified will be promptly corrected and logged on facility QA log to be reviewed in the monthly Quality Assurance meeting.</p>				

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	<p>p.m., the Nurse Consultant indicated the CNA Job Description and the Nurse Aide Training Program did not indicated the CNA's could tube feeding infusion pumps on and off. The Nurse Consultant indicated the CNA's should not be doing this.</p> <p>STANDARD 14. NURSE AIDE SCOPE OF PRACTICE http://www.in.gov/isdh/files/stand14_b.pdf.</p> <p>The nurse aide will perform only the tasks in the course standards and Resident Care Procedures manual, unless trained appropriately by licensed staff of the facility with policies and procedures and a system for ongoing monitoring to assure compliance with the task, i.e., (see supplements for examples). This additional training would only apply for tasks, which are not prohibited by paragraphs 2 and 3 of this section and by current rule, which prohibits the giving of injections.</p> <p>The nurse aide will not perform any invasive procedures, including enemas and rectal temperatures, checking for and/or removing fecal impactions, instillation of any fluids, through any tubing, administering vaginal or rectal installations.</p> <p>The nurse aide will not administer any medications, perform treatment</p>				

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F000514 SS=E	<p>or apply or remove any dressings. Exception to the above would be the application of creams/ointments to intact skin, such as moisture barrier cream</p> <p>This Federal tag relates to Complaint IN00155220.</p> <p>3.1-14(i)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview the facility failed to ensure clinical records were accurate and complete related to medications and treatments not signed out as ordered and lack of follow up assessment documentation after a change in condition or new medications ordered</p>	F000514	It is the policy of Miller's Merry Manor, La Porte to maintain clinical records on each resident in accordance with accepted professional standards of practice that are complete; accurately documented; readily accessible; and systemically organized.	10/18/2014			

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	<p>for 4 of 4 residents reviewed for accurate and complete clinical records in the sample of 4. (Residents #C, #D, #E & #G)</p> <p>Findings include:</p> <p>1. The closed record for Resident #E was reviewed on 9/17/14 at 10:05 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, stroke, high blood pressure, and a history of an ankle fracture.</p> <p>The 4/30/14 Minimum Data Set quarterly assessment indicated the resident's cognitive skills for daily decision making were severely impaired. The assessment also indicated the resident required extensive assist (resident involved in activity, staff provide weight-bearing support) of one staff member for bed mobility, dressing, and personal hygiene.</p> <p>The 6/2014 and 7/2014 Medication Records were reviewed. There was a Physician's order for Nystatin (a medication to treat fungal infections) powder to be applied to the groin rash three times a day. The Nystatin powder was to be applied once a shift. The Nystatin powder was not signed out as completed on the following dates: 6/12/14- the day and evening shifts.</p>		<p>Resident C, D, G: Clinical records will be complete, accurate, and organized.</p> <p>Resident E: has been discharged from the facility:</p> <p><i>All residents are at risk to be affected by the deficient practices.</i></p> <p>An in-service for all licensed nursing staff will be held on or before 10/18/2014. The importance of accurate, organized, and complete documentation will be reviewed. Licensed nurses will be instructed on the importance of signing medications and/or treatments out on MAR/TAR after completing the task. The policies for "Notification of Changes", "Pertinent Charting" and "Medication Pass Procedure" will be reviewed. Residents on ATB therapy or with a significant change in status will be placed on the facility "Hot Sheet". The hot sheet serves as a pertinent charting log to communicate resident status changes requiring follow up documentation/assessment. Charge nurses will be instructed to document any physician notification and or changes in resident status in the residents EMR and on the facility 24hour report sheet. The nurse managers review the EMR and</p>	

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	<p>6/17/14- the evening and night shifts 6/18/14- the day, evening, and night shifts 6/21/14- night shift 6/25/14- the day shift 6/26/14- the evening shift 6/27/14 - the evening & night shifts 6/28/14- the night shift 7/13/14, 7/15/14 & 7/19/14- the night shifts</p> <p>There was also a Physician's order for Nystatin cream to be applied under the resident's right breast three times a day. The Nystatin cream was to be applied once a shift. The Nystatin cream was not signed out as completed on the following dates: 6/8/14- the evening shift 6/10/14, 6/11/14, & 6/12/14- the day shift 6/14/14 & 6/16/14- the evening shift 6/17/14- the day, evening, and night shifts 6/23/14 & 6/25/14- the day shift 6/26/14 & 6/27/14- the evening and night shifts 7/1/14- 7/3/14- the night shifts</p> <p>A Physician's order was written on 6/5/14 for the resident to have a Miconazole (a medication to treat fungal infections) vaginal suppository daily for seven days. The medication was signed out as given on the 6/2014 Medication Record from</p>		<p>24hour report sheet daily to monitor that significant changes in status are communicated to MD and family per policy. In addition, charting will be reviewed to ensure that pertinent charting is completed on changes in status such as ATB therapy/infection. The DON or other designee will be responsible to complete the QA tool titled "24 Hour Condition Review" (Attachment A) daily x 1week, then bi-weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected and logged on facility QA tracking log. The unit manager or other designee will complete bi-weekly MAR/TAR audits x4 weeks then weekly thereafter utilizing the QA tool "MAR/TAR Review" (Attachment B) to ensure that medications/treatments are being delivered as ordered by the physician. Any issues identified will be corrected upon discovery and logged on facility QA tracking log. The QA tracking logs are reviewed during the facility monthly QA meeting to ensure ongoing compliance.</p>				

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	<p>6/5/14 through 6/11/14. Another Physician's order was written on 7/16/14 for the resident to receive a Monistat vaginal suppository for seven days. The 7/2014 Medication Record indicated the vaginal suppository was given daily form 7/16/14 through 7/21/14.</p> <p>The 6/2014 Nursing Progress Notes were reviewed. An entry made on 6/5/14 at 5:30 p.m. indicated the resident had slight milky vaginal discharge. The Physician was notified and an order for Miconozole vaginal suppositories to be given daily for seven days was obtained. The next entries were made on 6/7/14 at 7:22 a.m. and 8:00 a.m. There was no follow up documentation related to the vaginal discharge or the new medication ordered. There was no further documentation related to the vaginal discharge or new medication given between 6/7/14 - 6/13/14.</p> <p>The 7/2014 Nursing Progress Notes were reviewed. There was only one entry made 7/16/14. This entry was made at 4:09 p.m. The entry indicated a new order was received from the Physician for Monistat (a medication to treat fungal infections) suppositories due to the a white vaginal discharge noted. There was no further documentation in the Progress Notes related to the vaginal</p>			

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	<p>discharge or the start of the new medication.</p> <p>When interviewed on 9/17/14 at the Nurse Consultant indicated the facility policy was to document a daily assessment after a change in condition or new treatment.</p> <p>2. The record for Resident #G was reviewed on 9/17/14 at 3:28 p.m. The resident's diagnoses included, but were not limited to, arthropathy, Chron's disease (a gastrointestinal illness), and esophageal reflux. The resident was admitted to the facility on 9/12/14.</p> <p>Review of the 9/2014 Medication Record indicated there was a Physician order for the resident to receive Metoporol (a cardiac medication) 50 milligrams twice a day at 9:00 a.m. and 9:00 p.m. There was also a Physician's order for the resident to receive Apixaban (a medication for irregular heart rhythm) 2.5 milligrams twice a day at 9:00 a.m. and 9.00 p.m. There was also a Physician's order for the resident to receive Calcium Citrate one tablet daily at 9:00 a.m. The 9:00 a.m. doses of the above three medications were not signed out as given 9/13/14 & 9/14/14.</p> <p>3. The record for Resident #C was</p>						

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	<p>reviewed on 9/17/14 at 9:26 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, depressive disorder, gastrostomy tube, and cardiovascular disease.</p> <p>The 9/2014 Medication Records were reviewed. There was an order for the resident to receive Calmoseptine ointment to the buttock each shift for redness. The Calmoseptine was not signed out as given on the followings dates/shifts: 9/2/14- day shift 9/4/14, 9/5/14, & 9/7/14- evening and night shifts 9/10/14- day and night shifts 9/14/14- day, evening, & night shifts</p> <p>There was another order for the resident to receive apply Nystatin (a medication to treat fungal infections) powder to a rash under the resident's left breast three times daily at 6:00 a.m., 2:00 p.m., and 10:00 p.m. The Nystatin was not signed out as completed on the following dates/times and shifts: 9/3/14, 9/9/14, & 9/15/14- 6:00 a.m. doses 9/4/14 & 9/5/14- 6:00 a.m., 2:00 p.m., & 10:00 p.m. doses 9/13/14 & 9/14/14- 10:00 p.m. doses</p> <p>There was another order for the staff to</p>			

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	<p>clean the resident's eyelids with baby shampoo three times a day at 9:00 a.m., 2:00 p.m., and 9:00 p.m. before the Gentak (eye drops) were given. The treatment was not signed out as completed at the following dates/times: 9/2/14- 9:00 a.m. & 2:00 p.m. 9/4/14 - all three doses 9/5/14- 9:00 a.m. and 9:00 p.m.</p> <p>The 8/2014 Medication Record was reviewed. There was a Physician's order written on 8/8/14 to apply Bacitracin (an antibiotic ointment) to the gastrostomy tube site twice a day at 6:00 a.m. and 8:00 p.m. daily for one week. The Bacitracin treatment was not signed out as completed on the following dates/times: 8/9/14 & 8/15/14- 6:00 a.m. & 8:00 p.m. 8/10/14 through 8/13/14 at 6:00 a.m. 8/15/14 - 6: a.m. & 8:00 p.m.</p> <p>4. The record for Resident #D was reviewed on 9/17/14 at 9:35 a.m. The resident's diagnoses included, but were not limited to, anemia, gastrostomy tube, high blood pressure, pneumonia, esophageal reflux, and diabetes mellitus.</p> <p>The 6/2014 Medication Record was reviewed. There was a Physician's order written on 6/19/14 for the resident to receive Levaquin (an antibiotic) 500</p>			

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	<p>milligrams once a day at 9:00 p.m. for 10 days.</p> <p>The 6/2014 Nursing Progress Notes were reviewed. An entry made on 6/19/14 at 9:09 a.m. indicated the Physician was notified of the chest X-ray results and orders were obtained for Levaquin 500 milligrams to be given daily for seven days. Continued review of the Progress Notes from 6/19/14 at 9:09 a.m. thru 6/22/14 indicated there was no assessment of the resident's respiratory condition.</p> <p>A Medication Change Follow-up Assessment form was completed on 6/19/14 at 5:20 a.m. The form indicated there were new orders for the resident to receive Levaquin. The form also indicated rhonchi (abnormal breath sounds) noted in the resident's lungs and the resident had a loose cough.</p> <p>A Nursing Infection Assessment form was completed on 6/21/14 at 7:08 p.m. The form indicated rhonchi lung sounds were noted and the resident had an infrequent cough.</p> <p>There were no further Nursing Infection Assessments or Medication Change Follow-up Assessment completed for the rest of the days the resident received the</p>			

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	<p>Levaquin.</p> <p>The 9/2014 Medication Record was reviewed. There was a Physician's order for the resident to receive Prevacid (a medication to treat esophageal reflux) 30 milligrams tab dissolved in water and given through the gastrostomy tube daily at 6:45 a.m. The medication was not signed out as given 9/10/14, 9/13/14 & 9/15/14.</p> <p>There were also orders for the resident to receive Centamin (a vitamin supplement) liquid 15 ml's (milliliters) per the gastrostomy tube daily at 9:00 a.m., Furosemide (a diuretic) 40 milligrams via the gastrostomy tube daily at 9:00 a.m., and Ferrous Sulfate (an iron supplement) 330 milligrams via the gastrostomy tube twice daily at 9:00 a.m. & 9:00 p.m. The above three medications were not signed out as administered at 9:00 a.m. on 9/11/14.</p> <p>There was also an order for the resident to receive Metformin (a medication to treat diabetes) 500 milligrams via the gastrostomy tube twice daily at 7:30 a.m. and 5:00 p.m. The 5:00 p.m. doses were not signed out as given on 9/5/14, 9/8/14, and 9/15/14.</p> <p>The facility policy titled "Charting</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155297	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S HEALTH & REHAB BY MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350
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	<p>Procedure" was reviewed on 9/17/14 at 3:35 p.m. The policy had a start date of 4/15/2014. The Nurse Consultant provided the policy and indicated the policy was current. The policy indicated Pertinent Charting documentation for all pertinent issues was to be completed in the progress notes or the assessment modules. The policy also indicated the charting was to be "completed daily or more often until resolved or stable."</p> <p>When interviewed on 9/17/14 at 3:35 p.m., the Nurse Consultant indicated daily assessment charting should have been completed for resident's with signs or symptoms when new medications were started for infections for residents.</p> <p>This Federal tag relates to Complaint IN00155220.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			