

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00182360 and IN00181509.</p> <p>Complaint IN00182360 Substantiated, Federal/State deficiencies related to the allegations are cited at F157, F225, F226, F323, and F282.</p> <p>Complaint IN00181509 Substantiated, Federal/State deficiencies related to the allegations are cited at F371.</p> <p>Survey dates: October 27, 28 and 29, 2015</p> <p>Facility number: 000174 Provider number: 155274 AIM number: 100274810</p> <p>Census bed type: SNF: 1 SNF/NF: 50 Total: 51</p> <p>Census payor type: Medicare: 1 Medicaid: 40 Other: 10 Total: 51</p> <p>Sample: 10</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=E Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC16.2-3.1.</p> <p>Quality review completed by #02748 on 11/9/15.</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 under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>						

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	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview, and record review, the facility failed to ensure notification of family and physicians occurred per facility policy for 5 of 5 residents reviewed for notifications. (Resident O, Resident M, Resident F, Resident H, Resident K)</p> <p>Findings include:</p> <p>1. Resident M was observed on 10/27/15 at 9:06 A.M., sitting on a sofa in the East 1 nursing lounge in no apparent distress.</p> <p>The clinical record for Resident M was reviewed on 10/27/15 at 1:45 P.M., the diagnoses included but were not limited to, dementia, and heart, nasal fracture and fracture of C5 (cervical spinal).</p> <p>The Minimum Data Set (MDS) assessment, for Resident M dated 6/7/15 indicated Resident M had a Brief Interview for Mental Status (BIMS) score of 5. Indicating he/she was severely cognitively impaired.</p> <p>The Nurses notes were reviewed and included, but were not limited to, 7/23/15 at 8:00 P.M., "When getting</p>	F 0157	<p>F157 E NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>It is the policy of Miller's Merry Manor, Rockport to promptly inform the resident, consult with resident's physician, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status and/or the need to alter treatment significantly.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident M – Family/responsible party was notified of bruise on left outer breast on 7/28/15. · Resident O – Physician and family/responsible party were notified 10/28/15 of the medication error. Medication Error Report form was completed per policy on 10/28/15. · Resident F – Family/responsible party was notified of incident regarding 	11/20/2015
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	<p>resident ready for bed, discovered a large bruise on left outer breast 11.5cm [sic] [centimeters] by 7.5cm [sic]. Resident denies knowledge of any incident causing bruise."</p> <p>A nurse's note dated 7/24/15 at 1:55 A.M., indicated a new order was obtained to monitor bruise to left outer breast x 7 days until resolved.</p> <p>The nurse's notes lacked any documentation the family had been notified of the bruising.</p> <p>During an interview with the Director of Nursing (DON) on 10/28/15 at 12:00 P.M., she indicated she was unaware of the bruise to Resident M's breast and it had not been reported to her.</p> <p>During an interview with the Administrator in Training (AIT) on 10/28/15 at 12:15 P.M. she indicated she could find no documentation to suggest the bruise to Resident M's breast had been reported to the family..</p> <p>2. During an observation on 10/27/15 at 12:45 P.M., Resident O was observed sitting in a wheel chair with his/her feet elevated using foot rests. Resident O was observed to be wearing foam positioning devices on both feet.</p>		<p>changes in skin integrity on 11/16/15.</p> <ul style="list-style-type: none"> Resident H – Family/responsible party was notified of incident regarding changes in skin integrity on Resident K – Family/responsible party was notified of incident regarding changes in skin integrity and new orders on 8/31/15 <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. Point Click Care's 24 Hour Condition Report to be reviewed on a daily basis by the interdisciplinary team to ensure physician and family notification has been completed for all condition changes. <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> All licensed nursing staff will be in-serviced on facility policy for <u>Notification of Changes</u> (Attachment A) and <u>Incident and</u> 		

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	<p>The clinical record for Resident O was reviewed on 10/27/15 at 10:15 A.M., the diagnoses included but were not limited to, Methicillin-resistant Staphylococcus aureus (MRSA) (a multi drug resistant bacteria), and cellulitis with abscess to foot, and osteomyelitis (an infection of the bone).</p> <p>The physican orders for Resident O included, but were not limited to, an order from a wound care physician on 6/17/15, "place PICC [peripherally inserted central catheter]", " IV Vancomycn (sic) x 6 weeks. 1st dose @ [at] hsp [hospital] with PICC placement." The hospital discharge orders for Resident O included, but were not limited to, "Administer 1750 milligrams [mg] IV over 120 minutes on 6-19-15 at 1500 [3:00 P.M.]. Vanco [vancomycin] trough to be drawn at 1430 [2:30 P.M.] on 6-20-15 and then nursing home pharmacy to dose future"</p> <p>An "IV ORDERS" form dated 6/23/15 from [name of pharmacy] included but was not limited to, "1) GIVE VANCOMYCIN 1750 mg IV today @ 12N [12:00 P.M.] (instead of 2p) [2 P.M.] then *CHANGE* dose of Vancomycin TO 2gm [gram] IV q [every] 24 [hours] at 6 AM [6:00 A.M.] start Wed [Wednesday] 6/24 6AM) [sic], 2. Draw next Tr [Trough], ... 1/2 [one</p>		<p><u>Accident Reporting</u> (Attachment B) completion date 11/20/15.</p> <ul style="list-style-type: none"> All new condition changes will be monitored by nurse management team by reviewing Point Click Care's 24 Hour Condition Report to ensure family/responsible party and physician notification. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> <u>24 Hour Condition Report Review QA tool</u> (Attachment C) will be utilized 5 X a week X 4 weeks, weekly X 1 month, and monthly thereafter to ensure timely and appropriate physician and family/responsible party notification. Any identified trends will be corrected upon discovery, documented on facility QA tracking log, and reported during monthly QA Committee meeting overseen by the Administrator. 				

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	<p>half] hr [hour] before Monday 6/29/15 dose...". The order was noted by a nurse on 6/23/15.</p> <p>The Medication Administration Record (MAR) for June were reviewed and included, but were not limited to, "Vancomycin HCl [Hydrochloride] Solution Reconstituted Use 2000 mg intravenously one time only for Give at 0800 pm [sic] on 6/24/15 for 1 day start 6/24/15 0600 [6:00 A.M.]. The record lacked documentation that Resident O had received Vancomycin on 6/25/15 and 6/26/15 was observed.</p> <p>A fax sheet from [name of pharmacy] dated 6/27/15 at 1:00 A.M., included a hand written note from a nurse, "I asked pharmacy why they sent 3 vancomycin balls because we only had a 1 time order on 6/24/15 which I gave. He then faxed me these papers showing the orders were for once a day until the 29th. No orders found in MAR or in computer to give past 6/24/15."</p> <p>During an interview with the Director of Nursing (DON) on 10/27/15 at 11:52 A.M., she indicated, Resident O was omitted with osteomyelitis to his/her right lower extremity and subsequently found to have MRSA in the wound and was ordered to have IV vancomycin by his/her wound care physician. The DON further indicated she could provide no documentation the antibiotic had been</p>			

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	<p>administered on 6/25/15 and 6/26/15. She further indicated the omittance of the medication was considered a medication error and should have been reported to herself, the physician and the family. The DON indicated she could provide no documentation of this being completed. On 10/27/15 at 1:00 P.M., the Administrator in Training (ATI) provided the following policy's for review: A policy titled "New Orders-Verbal/Telephone (Medrec)" dated 7/14/08 included, but was not limited to, "A. To ensure physician orders are transcribed correctly and carried out per plan.... Procedure: I. Transcribe new orders on physician T/O [telephone order]...VI. Fax all orders to pharmacy..."</p> <p>3. The clinical record of Resident F was reviewed on 10/28/15 at 2:00 P.M. The record indicated Resident F was readmitted on 3/14/14 with diagnoses including, but not limited to, history of a closed fracture of the intertrochantic section of the femur (hip fracture), Alzheimers disease, muscle weakness, and depression.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 1/20/15 and 9/19/15 indicated Resident F experienced severe cognitive impairment, required the assistance of 2 staff with transfers,</p>			

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	<p>walking, toileting and was always incontinent.</p> <p>A Care Plan for "SKIN RISK" dated 03/20/14 read as follows: "Notify physician and family of any changes in skin integrity."</p> <p>A Nursing-New Skin Alteration Assessment (non-occurrence) dated 9/7/15 at 00:49 (12:49A.M.), read as follows: "...resident noted to have a purple Bruise to Top of Left Wrist measuring 5.5 cm X 4.5 cm (centimeters). there is small scattered bruising to the Top of Left Forearm as well as Top Left Bicept (sic). Resident denies any knowledge of how bruising occurred (sic) and denies pain at this time..." The clinical record lacked any documentation the family/responsible party was notified of the bruising.</p> <p>During an interview on 10/29/15 at 11:55 A.M., the Director of Nursing indicated the family should have been notified concerning the bruising indentified on 9/7/15 at 12:49 A.M.</p> <p>4. The clinical record of Resident H was reviewed on 10/28/15 at 3:52 P.M. The record indicated Resident H was admitted on 9/16/11 with diagnoses including, but not limited to, depression,</p>			

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	<p>cerebrovascular accident with hemiplegia.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 9/1/15 indicated Resident H experienced severe cognitive impairment, required the assistance of 2 staff with transfers and toileting.</p> <p>A Care Plan for "SKIN RISK" dated 9/19/13 read as follows: "Notify physician and family of any changes in skin integrity."</p> <p>A Nursing-New Skin Alteration Assessment (non-occurrence) dated 9/6/15 at 06:50 (6:50A.M.), read as follows: "...Resident has a dark reddish/purple Bruise to Left Top of Forearm measuring 6 cm X 3.75 cm. Resident denies any knowledge of how bruising occurred and denies any pain at this time. Resident also has a scabbed 3 cm S/T (skin tear) to Outer Aspect of Left Bicep edges approximated and healing well. 8 (Eight) soiled steri strips loosely intact with ends of strips curling up. R%esident (sic) denies knowledge of how S/T occurred. Resident denies pain at this time. M.D. notified..." The clinical record lacked any documentation the family/responsible party was notified about the bruising or skin tear.</p>			

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	<p>During an interview on 10/29/15 at 11:55 A.M., the Director of Nursing indicated the family should have been notified concerning the bruising and skin tear to left bicep which was indentified on 9/6/15 at 6:50 A.M.</p> <p>5. The clinical record of Resident #K was reviewed on 10/29/15 at 4:15 P.M. The record indicated Resident #K was admitted on 1/2/12 with diagnoses including, but not limited to, depression, cerebrovascular accident with left hemiplegia and hemiparesis.</p> <p>The Annual MDS (Minimum Data Set) assessment dated 7/7/15 indicated Resident K experienced severe cognitive impairment, required the assistance of 2 staff with transfers and toileting.</p> <p>A Care Plan for "SKIN RISK" dated 1/2/12 read as follows: "Notify physician and family of any changes in skin integrity."</p> <p>A Nursing-New Skin Alteration Assessment (non-occurrence) dated 8/30/15 at 15:48 (3:48 A.M.), read as follows: "...Resident taking off her jacket and got a skin tear to left forearm. States she scratched with her fingernail." The clinical record lacked any documentation the family/responsible party was notified</p>			

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F 0225 SS=D Bldg. 00	<p>about the skin tear.</p> <p>A policy titled "Physician & Family Notification of Condition Changes" dated 3/1/2003 included, but was not limited to, "...Purpose: 1. To keep the physician, resident and family apprised of all condition changes... PROCEDURE: ...b. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan... FAMILY NOTIFICATION 1. Notify the resident and responsible party of any change in condition that may or may not warrant a change in the treatment plan..."</p> <p>During an interview on 10/29/15 at 7:55 A.M., the Wound Care Nurse indicated the family should have been notified concerning the 1X1 cm skin tear to left forearm which was indentified on 9/6/15 at 6:50 A.M.</p> <p>This Federal tag relates to Complaint IN00182360.</p> <p>3.1-5(a)(3)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered</p>			

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	<p>into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview and record review, the facility failed to ensure injuries of unknown origin were reported timely to the facility administration, resident ' s families and to the Indiana State Department of Health for 1 of 4 residents who met the criteria for review</p>	F 0225	<p>F225 D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>It is the policy of Miller's Merry Manor, Rockport to ensure abuse allegations are thoroughly investigated. It is the policy of</p>	11/20/2015			

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	<p>of Abuse Prohibition. (Resident M)</p> <p>Findings include:</p> <p>1. Resident M was observed on 10/27/15 at 9:06 A.M., sitting on a sofa in the East 1 nursing lounge in no apparent distress.</p> <p>The clinical record for Resident M was reviewed on 10/27/15 at 1:45 P.M., the diagnoses included but were not limited to, dementia, and heart, nasal fracture and fracture of C5.</p> <p>The Minimum Data Set (MDS) assessment, for Resident M dated 6/7/15 indicated Resident M had a Brief Interview for Mental Status (BIMS) score of 5. Indicating he/she was severely cognitively impaired.</p> <p>The Nurses notes were reviewed and included, but were not limited to, 7/23/15 at 8:00 P.M., "When getting resident ready for bed, discovered a large bruise on left outer breast 11.5cm [sic] [centimeters] by 7.5cm [sic]. Resident denies knowledge of any incident causing bruise." The record lacked any documentation of how the bruise had occurred.</p> <p>A nurse's note dated 7/24/15 at 1:55 A.M., indicated a new order was obtained</p>		<p>Miller's Merry Manor, Rockport to report all incidents to the Long Term Care Division of the Indiana State Department of Health.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. All residents and/or family will be interviewed monthly using the QIS Resident Interview Questionnaire to ensure residents have been treated with respect and dignity. All new skin alterations will be monitored by interdisciplinary team on a daily basis to asses for potential mishandling/abuse. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p>				

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	<p>to monitor bruise to left outer breast x 7 days until resolved.</p> <p>The nurse's notes lacked any documentation the family, Administrator and State Department of Health had been notified of the bruise.</p> <p>During an interview with the Director of Nursing (DON) on 10/28/15 at 12:00 P.M., she indicated she was unaware of the bruise to Resident M's breast and it had not been reported to her.</p> <p>During an interview with the Administrator in Training (AIT) on 10/28/15 at 12:15 P.M. she indicated she could find no documentation to suggest the bruise to Resident M's breast had been reported. She indicted the bruise should have been investigated and reported to the State Department of Health due to both the location and the size.</p> <p>A policy titled "Incident Reporting to the ISDH" dated 7/15/15 included but was not limited to,"... It is the policy of Miller's Merry Manor to report all incidents (formally known as unusual occurrences) to the Long Term Care Division of the Indiana State Department of Health... ..A full investigation will be</p>		<ul style="list-style-type: none"> All staff will be in-serviced on <u>Abuse Prohibition, Reporting, and Investigation</u> (Attachment D) policy and <u>Incident Reporting to the ISDH</u> (Attachment E) policy completion date 11/20/15. <u>Investigation of Injury of Unknown Origin</u> (Attachment F) form will be put into place completion date 11/20/15 to ensure injuries of unknown origin and suspicious injuries are documented according to policy and state reportable guidelines. All new injuries of unknown origin will be monitored by nurse management team to ensure injuries of unknown origin and suspicious injuries are documented according to policy and state reportable guidelines. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> <u>24 Hour Condition Report Review</u> QA tool (Attachment C) will be utilized 5 X a week X 4 weeks, weekly X 1 month, and monthly thereafter to ensure initial occurrences are reviewed and investigations are initiated timely. Any identified trends will be corrected upon discovery, documented on facility QA 				

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	<p>conducted to accurately determine the cause(s) of the incident. The investigation must include: A. Location of incident B. Person(s) involved in the incident C. Environment D. Physical status of the resident involved. E. Summary of the investigation including a conclusion. If the incident is determined as a "reportable incident" by the Administrator or designee will be responsible for contacting the ISDH by the use of the Incident Reporting System on the ISDH Gateway..... TYPES OF INCIDENTS REPORTABLE UNDER FEDERAL AND STATE RULES: ...ABUSE... ...MISTREATMENT... ...INJURIES OF UNKNOWN SOURCE... ...An injury should be classified as an injury of unknown source when both the following conditions are met: ...The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and B. The injury is suspicious because of the extent of the injury or the location of the injury (i.e. the injury is located in an area not generally vulnerable to trauma)Examples of suspicious injuries:... ...Marks or</p>		tracking log, and reported during monthly QA Committee meeting overseen by the Administrator.		

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F 0226 SS=D Bldg. 00	bruising... ..in the genital or breast area..." This Federal tag relates to Complaint IN00182360. 3.1-28(c) 3.1-28(d) 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure allegations of abuse were completely and toughly investigated for 1 of 3 allegations reviewed. The facility also failed to implement their abuse prohibition policy when injuries of unknown origin were identified and failed to investigate the origins, notify the Administrator, families, physicians and the Indiana State Department of Health. (Resident M, Resident Q, Resident Y) Findings include: 1. Resident Q was observed on 10/27/15 at 11:30 A.M., sitting in his/her room in	F 0226	F226 D DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES It is the policy of Miller's Merry Manor, Rockport that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident Q – All staff in-serviced on policy <u>Abuse Prohibition, Reporting, and Investigating</u> (Attachment D) completion date 11/20/15 to ensure all allegations are investigated appropriately and	11/20/2015	

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	<p>no apparent distress.</p> <p>A reportable incident involving Resident Q was reviewed on 10/27/15 at 2:00 P.M., it included, 9/4/15 at 8:01 A.M., Resident Y reported an allegation of mistreatment of Resident Q by RN #2. RN #2 was suspended pending an investigation; the facility Administrator, resident's family and physician were notified. The allegation was unsubstantiated and staff was educated on proper treatment/transfer technique. Resident Y was educated on allowing staff to assist Resident Q.</p> <p>The clinical record for Resident Q was reviewed on 10/27/15 at 1:22 P.M., diagnoses included, but were not limited to, abdominal pain, anxiety, and osteoporosis.</p> <p>The Minimum Data Set (MDS) assessment for Resident Q dated 10/5/15 indicated Resident Q had a Brief Interview for Mental Status (BIMS) score of 6 indicating he/she was severely cognitively impaired.</p> <p>2. Resident M was observed on 10/27/15 at 9:06 A.M., sitting on a sofa in the East 1 nursing lounge in no apparent distress.</p> <p>The clinical record for Resident M was</p>		<p>thoroughly. · Resident M – One on one education provided to all licensed nurses regarding <u>Incident Reporting to the ISDH (Attachment E)</u> policy to ensure all injuries of unknown origin and injuries in suspicious locations are investigated thoroughly and reported to the administrator, physician, family/responsible party, and ISDH How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · All staff will be in-serviced on <u>Abuse Prohibition, Reporting, and Investigation (Attachment D)</u> policy and <u>Incident Reporting to the ISDH (Attachment E)</u> policy completion date 11/20/15. · <u>Investigation of Injury of Unknown Origin (Attachment F)</u> form will be put into place completion date 11/20/15 to ensure injuries of unknown origin and suspicious injuries are documented according to policy and state reportable guidelines. · All new injuries of unknown origin will be monitored by nurse management team to ensure injuries of unknown origin and suspicious injuries are documented</p>	

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	<p>reviewed on 10/27/15 at 1:45 P.M., the diagnoses included but were not limited to, dementia, and heart, nasal fracture and fracture of C5.</p> <p>The Minimum Data Set (MDS) assessment, for Resident M dated 6/7/15 indicated Resident M had a Brief Interview for Mental Status (BIMS) score of 5. Indicating he/she was severely cognitively impaired.</p> <p>The Nurses notes were reviewed and included, but were not limited to, 7/23/15 at 8:00 P.M., "When getting resident ready for bed, discovered a large bruise on left outer breast 11.5cm [sic] [centimeters] by 7.5 cm [sic]. Resident denies knowledge of any incident causing bruise."</p> <p>A nurse's note dated 7/24/15 at 1:55 A.M., indicated a new order was obtained to monitor bruise to left outer breast x 7 days until resolved.</p> <p>The nurse's notes lacked any documentation the family, Administrator and State Department of Health had been notified of the bruise.</p> <p>During an interview with the Director of Nursing (DON) on 10/28/15 at 12:00 P.M., she indicated she was unaware of</p>		<p>according to policy and state reportable guidelines. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · <u>24 Hour Condition Report Review</u> QA tool (Attachment C) will be utilized 5 X a week X 4 weeks, weekly X 1 month, and monthly thereafter to ensure initial occurrences are reviewed and investigations are initiated timely. · <u>Abuse</u> QA tool (Attachment G) will be utilized 5 X a week for 4 weeks, weekly X 1 month, and monthly thereafter. · Any identified trends will be corrected upon discovery, documented on facility QA tracking log, and reported during monthly QA Committee meeting overseen by the Administrator. 				

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	<p>the bruise to Resident M's breast and it had not been reported to her.</p> <p>During an interview with the Administrator in Training (AIT) on 10/28/15 at 12:15 P.M. she indicated she could find no documentation to suggest the bruise to Resident M's breast had been reported. She indicted the bruise should have been investigated and reported to the State Department of Health due to both the location and the size.</p> <p>A policy titled "Incident Reporting to the ISDH" dated 7/15/15 included but was not limited to, "... It is the policy of Miller's Merry Manor to report all incidents (formally known as unusual occurrences) to the Long Term Care Division of the Indiana State Department of Health... ..A full investigation will be conducted to accurately determine the cause(s) of the incident. The investigation must include: A. Location of incident B. Person(s) involved in the incident C. Environment D. Physical status of the resident involved. E. Summary of the investigation including a conclusion. If the incident is determined as a "reportable incident" by the Administrator or designee will be responsible for contacting the ISDH by the use of the Incident Reporting System</p>			

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	<p>on the ISDH Gateway..... TYPES OF INCIDENTS REPORTABLE UNDER FEDERAL AND STATE RULES: ...ABUSE... ...MISTREATMENT... ...INJURIES OF UNKNOWN SOURCE... ...An injury should be classified as an injury of unknown source when both the following conditions are met: ...The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and B. The injury is suspicious because of the extent of the injury or the location of the injury (i.e. the injury is located in an area not generally vulnerable to trauma) ... Examples of suspicious injuries:... ...Marks or bruising... ...in the genital or breast area..."</p> <p>A policy titled "Abuse Prohibition, Reporting, and Investigation" dated 7/15/15 was provided by the AIT on 10/27/15 at 12:00 P.M., the policy included, but was not limited to, "1. It is the policy of Miller's Health Syhstems that all residents have the right to be free from verbal, sexual, physical and mental abuse... ...3. Miller's Health Systems has policies and procedures in place that ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source...are reported immediately to the</p>			

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F 0282 SS=D Bldg. 00	<p>Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)... 4. INJURIES OF UNKNOWN SOURCE-An injury should be classified as an Injury of Unknown Source when BOTH of the conditions are met: The source of the injury was not observed by any person or the source of the injury was not observed by any person or the source of the injury could not be explained by the resident: AND The injury is suspicious because of the extent of the injury or the location of the injury..Marks of bruising...in genital or breast area..."</p> <p>This Federal tag relates to Complaint IN00182360.</p> <p>3.1-28(a)</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, interview, and record review, the facility failed to ensure antibiotics were administered per the</p>	F 0282	F282 D SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	11/20/2015

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	<p>physician's orders for 1 of 3 residents who met the criteria for review of physician's orders. (Resident O)</p> <p>Findings include:</p> <p>1. During an observation on 10/27/15 at 12:45 P.M., Resident O was observed sitting in a wheel chair with his/her feet elevated using foot rests. Resident O was observed to be wearing foam positioning devices on both feet.</p> <p>The clinical record for Resident O was reviewed on 10/27/15 at 10:15 A.M., the diagnoses included but were not limited to, Methicillin-resistant Staphylococcus aureus (MRSA) (a multi drug resistant bacteria), and cellulites with abscess to foot, and osteomyelitis (an infection of the bone).</p> <p>The orders for Resident O included, but were not limited to, an order from a wound care physician on 6/17/15, "place ICC [peripherally inserted central catheter]", " IV Vancomycin [sic] x 6 weeks. 1st dose @ [at] hsp [hospital] with PICC placement.", The hospital discharge orders for Resident O included, but were not limited to, "Administer 1750 milligrams [mg] IV over 120 minutes on 6-19-15 at 1500 [3:00 P.M.]. Vanco [vancomycin] trough to be drawn at 1430 [2:30 P.M.] on 6-20-15 and then</p>		<p>It is the policy of Miller's Merry Manor, Rockport to ensure physician orders are transcribed correctly and carried out per plan. It is the policy of Miller's Merry Manor, Rockport to safeguard the resident.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident O – Physician and family/responsible party notified on 10/28/15. Entry of the incident was documented on the resident's clinical record and medication error report. Resident did not encounter any negative outcome from this error. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> <u>Medication and Treatment Error Report</u> (Attachment H) will 				

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	<p>nursing home pharmacy to dose future". An "IV ORDERS" form dated 6/23/15 from [name of pharmacy] included but was not limited to, "1) GIVE VANCOMYCIN 1750 mg IV today @ 12N [12:00 P.M.] (instead of 2p) [2 P.M.] then *CHANGE* dose of Vancomycin TO 2gm [gram] IV q [every] 24 [hours] at 6 AM [6:00 A.M.] start Wed [Wednesday] 6/24 6AM) [sic], 2. Draw next Tr [Trough], ... 1/2 [one half] hr [hour] before Monday 6/29/15 dose...". The order was noted by a nurse on 6/23/15.</p> <p>The Medication Administration Record (MAR) for June were reviewed and included, but were not limited to, "Vancomycin HCl [Hydrochloride] Solution Reconstituted Use 2000 mg intravenously one time only for Give at 0800 pm [sic] on 6/24/15 for 1 day start 6/24/15 0600 [6:00 A.M.]. No documentation Resident O had received Vancomycin on 6/25/15 and 6/26/15 was observed.</p> <p>A fax sheet from [name of pharmacy] dated 6/27/15 at 1:00 A.M., included a hand written note from a nurse, "I asked pharmacy why they sent 3 vancomycin balls because we only had a 1 time order on 6/24/15 which I gave. He then faxed me these papers showing the orders were for once a day until the 29th. No orders found in MAR or in computer to give</p>		<p>be implemented by 11/20/15 to ensure that all medication errors are followed up on according to policy and state guidelines.</p> <ul style="list-style-type: none"> All entered orders will be verified by two licensed nurses to ensure accuracy in transcription completion date 11/20/15. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> <u>MAR/TAR Review</u>QA tool (Attachment I) will be utilized 5 X a week X 4 weeks, weekly X 1 month, and frequency will be determined thereafter upon recommendation of the QAA Committee to ensure medication errors are appropriately documented and physician, family, and/or responsible party notification is completed timely. Any identified trends will be corrected upon discovery, documented on facility QA tracking log, and reported during monthly QA Committee meeting overseen by the Administrator. 				

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	<p>past 6/24/15."</p> <p>During an interview with the Director of Nursing (DON) on 10/27/15 at 11:52 A.M., she indicated, Resident O was admitted with osteomelitis to his/her right lower extremity and subsequently found to have MRSA in the wound and was ordered to have IV vancomycin by his/her wound care physician. The DON further indicated she could provide no documentation the antibiotic had been administered on 6/25/15 and 6/26/15. She further indicated the admittance of the medication was considered a medication error and should have been reported to herself, the physician and the family. The DON indicated she could provide no documentation of this being completed.</p> <p>On 10/27/15 at 1:00 P.M., the Administrator in Training (ATI) provided the following policy's for review:</p> <p>On 10/28/15 at 4:09 P.M., the DON provided a copy of a medication error report dated 10/27/15. It indicated a transcription error occurred on 6/23/15 resulting in Resident O missing two doses of Vancomycin on 6/25/15 and 6/26/15. The actions being taken were for all orders to be verified by two nurses at all times. The error report indicated the family and physician had been notified of the medication error on 10/28/15.</p> <p>A policy titled "New Orders-Verbal/Telephone (Medrec)"</p>			

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	<p>dated 7/14/08 included, but was not limited to, "A. To ensure physician orders are transcribed correctly and carried out per plan.... Procedure: I. Transcribe new orders on physician T/O [telephone order]...VI. Fax all orders to pharmacy..."</p> <p>A policy titled included, but was not limited to "...PURPOSE: To safeguard the resident...Medication errors and drug reactions must be reported immediately to the attending physician and responsible party...An entry of the incident must be made in the resident's clinical record and medication error report...Nurse/QMA [qualified medication aide] directly involved in the error will be re-educated and/or counseled..."</p> <p>A policy titled "Physician & Family Notification of Condition Changes" dated 3/1/2003 included, but was not limited to, "...Purpose: 1. To keep the physician, resident and family apprised of all condition changes... PROCEDURE: ...b. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan... FAMILY NOTIFICATION 1. Notify the resident and responsible party of any change in condition that may or may not warrant a change in the treatment plan.</p> <p>This Federal tag relates to Complaint IN00182360. 3.1-35(a)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
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F 0323 SS=G Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure, residents at risk to experience falls were provided with adequate supervision and effective interventions to prevent falls for 3 of 3 residents who met the criteria for review of accidents. This deficient practice resulted in Resident M experiencing a nasal and spinal fracture and Resident F experiencing acute closed head injury and laceration to the face requiring 8 sutures. (Resident M, Resident F, Resident G)</p> <p>Findings include:</p> <p>1. Resident M was observed on 10/27/15 at 9:06 A.M., sitting on a sofa in the East 1 nursing lounge. Resident M was observed to have a pad alarm and faded bruising under his/her eyes. The Unit Manager #2 indicated the bruising was from a recent fall.</p>	F 0323	<p>F323 G FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>It is the policy of Miller's Merry Manor, Rockport to assess all residents for risk factors that may contribute to falling and to provide planned interventions identified by the team as appropriate for resident use in maintaining or returning to the highest level of physical, social, and psychosocial functioning as possible.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident M – Fall Care Plan reviewed for effectiveness of interventions and updated with new fall interventions. · Resident F – Fall Care Plan reviewed for effectiveness of interventions and updated with 	11/20/2015

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	<p>The clinical record for Resident M was reviewed on 10/27/15 at 1:45 P.M., the diagnoses included but were not limited to, dementia, and heart, nasal fracture and fracture of C5.</p> <p>The Minimum Data Set (MDS) assessment, for Resident M dated 6/7/15 indicated Resident M had a Brief Interview for Mental Status (BIMS) score of 5. Indicating he/she was severely cognitively impaired.</p> <p>The care plan prior to 7/1/15 included, but was not limited to, a care plan for falls initiated 5/10/15. The interventions in place included, but were not limited to, Evaluate effectiveness and side effects of psychoactive medications (5/10/15), call light in reach 5/10/15, toilet every 2 hours while awake, offer toilet every 1 hour at bedtime (5/19/15) and, hip protectors at all times (6/9/15).</p> <p>The "Nursing-Occurrence Initial Assessment" forms for Resident M were reviewed and included:</p> <p>Fall #1 Resident M experienced an unwitnessed fall in the East 1 nursing lobby on 7/1/15 at 4:30 P.M. The report indicated resident M was found on the floor and complained of pain to right elbow. Resident M experience a skin tear</p>		<p>new fall interventions.</p> <ul style="list-style-type: none"> Resident G – Fall Care Plan reviewed for effectiveness of interventions and updated with new fall interventions. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. All resident's fall care plans reviewed by nursing management team to ensure accuracy and appropriate interventions completion date 11/20/15. <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Interdisciplinary team will review all falls to determine root cause and establish appropriate intervention. Resident's plan of care updated accordingly and new interventions communicated to staff. Completion date 11/20/15. All licensed nursing staff will be in-serviced on <u>Fall Management Procedure</u> (Attachment J) and 				

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	<p>to his/her elbow. No documentation of an immediate intervention was in place.</p> <p>The IDT (Interdisciplinary team) note dated 7/2/15 at 11:24 P.M., indicated the root cause of the fall was a lack of safety awareness related to decreased cognition and recommended resident M be monitored closely and redirected as needed.</p> <p>Fall #2 Resident M experienced an unwitnessed fall on 7/10/15 at 1:15 A.M. The document indicated Resident M was found on the floor in the bathroom of his/her room. Resident M experienced no injuries. No immediate intervention was documented on this sheet.</p> <p>The IDT note dated 7/10/15 at 1:00 P.M., indicated the root cause of this fall was decreased safety awareness, and recommended Resident M be checked every 2 hours.</p> <p>Fall #3 Resident M experienced an unwitnessed fall on 7/12/15 at 5:05 A.M. The document indicated Resident M was found on the floor in a sitting position in the floor in his/her room. Resident M had no injuries as a result of this fall. No documentation of an immediate intervention was observed.</p> <p>The IDT note dated 7/13/15 at 12:46</p>		<p><u>Interventions/Protocol List</u> (Attachment K) completion date 11/20/15.</p> <ul style="list-style-type: none"> <u>Fall Tracking Log</u>(Attachment L) will be utilized by interdisciplinary team by 11/20/15 to track trends in order to identify potential fall patterns. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> <u>Fall Risk Management Review</u>QA Tool (Attachment M) will be utilized by nurse management team for all falls weekly X 4 weeks and monthly thereafter completion date 11/20/15. Any identified trends will be corrected upon discovery, documented on facility QA tracking log, and reported during monthly QA Committee meeting overseen by the Administrator. 				

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	<p>P.M., indicated the root cause of this fall was decreased safety awareness related to a diagnosis of dementia.</p> <p>Fall #4 Resident M experienced an unwitnessed fall on 7/13/15 at 6:30 A.M. The document indicated Resident M was found lying in bed with blood on the sheets. Resident M was observed to have a skin tear on his/her left elbow and indicated he/she had fallen. No other injuries noted. Nero checks started. No documentation of an immediate intervention was observed. No IDT note addressing this incident was observed.</p> <p>Fall #5 Resident M experienced a witnessed fall on 8/20/15 at 11:00 A.M. The document indicated a housekeeper heard noise coming from the room of Resident M. The document continued and included, Resident fell before staff could get to her. Resident was lying in floor in front of bed with head against bed frame. The immediate intervention put into place was to send Resident M to the emergency room (ER) for evaluation and treatment. Resident M experienced no injuries as a result of the fall.</p> <p>The IDT note dated 8/20/15 at 1:47 P.M indicated the root cause for Resident Ms' falls continued to be decreased safety awareness related to a diagnosis of</p>			

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	<p>dementia. The recommendations continued to be resident to be monitored closely and toileted per schedule to assure needs are met.</p> <p>Fall #6 Resident M experienced unwitnessed fall on 9/12/15 at 2:30 P.M. The document indicated a Certified Nursing Assistant had observed Resident M lying on the floor at his/her bedside. The document included Resident M experienced pain and was sent to the local hospital for evaluation and treatment. Resident M experienced no injuries as a result of the fall. No IDT notes addressing this incident was observed.</p> <p>Fall #7 Resident M experienced an unwitnessed fall on 10/18/15 at 6:00 P.M., The document indicated Resident M was found on the floor in the bathroom floor of his/her room with active bleeding noted from the nose, mouth and head. The immediate intervention was to send Resident M to the emergency room for evaluation and treatment. Resident M was admitted to the hospital for observation and experienced a nasal fracture and a fracture of his/her cervical 5 vertebrate (spinal fracture).</p> <p>The IDT note dated 10/19/15 at 9:33</p>			

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	<p>A.M., indicated the root cause of the fall was toileting self, with no evidence of incontinence. The recommendations were to encourage and assist with wearing non skid footwear at all times.</p> <p>During an interview with the Director of Nursing (DON) on 10/28/15 at 12:00 P.M., she indicated Resident M had experienced several falls with the last resulting in a nasal and spinal fracture. The falls were reviewed with the DON and she indicated:</p> <p>Fall #1 Resident M was found lying on the floor in the lobby of the East 1 nursing lobby at 4:30 P.M. She indicated the fall was unwitnessed and Resident M experienced a skin tear to his/her right elbow. She further indicated the immediate intervention was to encourage resident to stay on the sofa in the nursing lounge.</p> <p>Fall #2 Resident M was found lying in the floor on 7/10/15 at 1:15 A.M., in his/her bathroom. She indicated, the fall was unwitnessed, Resident M experienced no injuries and the facility revised Resident Ms toileting schedule to include toileting every 2 hours at night time.</p> <p>Fall #3 Resident M was found lying in</p>			

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	<p>the floor near the his/her bedside. She indicated Resident M experienced no injuries and the immediate intervention was to ensure Resident M was wearing proper footwear at all times, offer divisional activities and hourly rounding for a week.</p> <p>Fall #4 Resident M was found lying in bed with a skin tear. She indicated Resident M indicated she had fallen so it was treated as an unwitnessed fall and nero (nerological) checks were initiated. She indicated no documentation of IDT note could be provided and the intervention put into place included, but was not limited to getting Resident M out of bed when he/she was unable to sleep.</p> <p>Fall #5 Resident M was observed to fall while attempting to ambulate in his/her room. She indicated Resident M was sent to the emergency room for evaluation of treatment and the interventions put into place included, monitor closely and toilet per schedule.</p> <p>Fall #6 Resident was found lying on the floor in floor in room on 9/12/15 at 2:30 P.M., Resident M was sent to local hospital for evaluation and treatment. She indicated no IDT note could be provided but the intervention added was to place Resident M to be in the lobby rather than</p>			

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	<p>in bed in the evenings. She indicated the intervention was not a new one.</p> <p>Fall #7 Resident M was found in a sitting position in the bathroom of his/her bathroom on 10/18/15 at 6:00 P.M. She indicated Resident M was observed to have active bleeding from her nose and head and was sent to the local hospital and admitted for observation. She indicated Resident M experienced a nasal fracture as well as a spinal fracture located at the cervical 5 vertebrae.</p> <p>The IDT note dated 10/19/15 at 9:33 A.M., indicated the root cause of the fall was toileting self and the immediate intervention put into place was to encourage resident to wear non skid footwear at all times, 15 minute checks indefinitely, and to place a chair alarm on Resident M. The DON indicated at this time that the previous interventions and supervision put into place for Resident M were ineffective.</p> <p>2. On 10/27/15 Resident F was observed from 10:10 A.M. through 1:10 P.M. Resident F was observed sitting on the couch in the East hall 2 lounge/restorative dining room from 10:10 A.M. until 11:25 A.M., at which time Resident F was transferred to a wheelchair and positioned at the</p>			

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	<p>restorative dining table until 1:10 P.M.</p> <p>Resident F was observed to be unsupervised in the lounge/restorative dining room with no staff between 10:10 A.M. and 10:15 A.M. When RN #2 was working at the nurses' station on East hall 2, residents who were seated in the lounge/restorative dining room were not within her view for supervision.</p> <p>The clinical record of Resident F was reviewed on 10/27/15 at 2:00 P.M. The record indicated Resident F was admitted on 3/14/14 with diagnoses including, but not limited to, history of a closed fracture of the intertrochanteric section of the femur (hip fracture), Alzheimer's disease, muscle weakness, and depression.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 1/20/15 and 9/19/15 indicated Resident F experienced severe cognitive impairment, required the assistance of 2 staff with transfers, was always incontinent and required the assistance of 2 staff for toileting.</p> <p>A Care Plan for falls dated 03/14/14 read as follows: "...Interventions/Tasks...Reinforce need to call for assistance. Date initiated: 3/25/15..." "Place on couch immediately following all meals...date initiated</p>			

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	<p>2/12/15...Resolved (discontinued) 10/27/15..."</p> <p>"8/3/15 res (resident) is not to be left up in w/c (wheelchair) unattended...Date initiated 8/5/2015."</p> <p>The undated "Nurse to CNA Report Sheet" provided by RN #2 on 10/27/15 at 10:15 A.M. read as follows for Resident F: "Sit on couch in lobby immediately after meals...is not to be left up in w/c unattended. HIGH FALL RISK..."</p> <p>The "Nursing-Occurrence Initial assessment and the Facility-Post Occurrence IDT and Fall Risk Assessment..." was provided by the Administrator in Training (AIT) on 10/27/15 at 4:30 P.M., and it indicated Resident F fell on the following days:</p> <p>Fall #1 occurred on 3/24/15 at 00:20 (12:20 A.M.). "...Called to room by resident's roommate...Resident sitting on floor with back against bed and beside table smiling. Denies injury. Denies hitting head...12 inch long red, bruised abrasion left back with a smaller 6 inch abrasion right beside it...Placed in w/c and moved to lobby..."</p> <p>A "Facility-Post Occurrence IDT and fall risk Assessment (DON or designee only)..." dated 3/31/15 at 9:59 A.M., read as follows: "...Resident go (sic) out of</p>			

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	<p>bed unassisted and slid to floor...Resident needing to toilet...Mat placed at bedside, Metal bar on side of bed covered with padding...Leave bathroom light on at night with door partially open to provide some lighting in room."</p> <p>Fall #2 occurred on 5/14/15 at 17:20 (5:20 P.M.). "...resident was sitting in w/c at table in main dining room. another resident stated resident sttod (sic) and fell. no injuries noted..." No Facility-Post Occurrence IDT and fall risk Assessment was provided.</p> <p>Fall #3 occurred on 6/8/15 at 19:30 (7:20 P.M.) "...res (resident) was sitting in w/c at dining room table facing nurses desk. this nurse was standing at med cart and heard res yelp, as this nurse turned around I witnessed res slide out of chair landing on butt sitting on floor..."</p> <p>A "Facility-Post Occurrence IDT and fall risk Assessment (DON or designee only)..." dated 6/9/15 at 9:46 A.M., read as follows: "...Resident attempted to transfer self from w/c to couch in auxiliary dining room et (and) fell...Root cause: Resident attempted to transfer self from w/c to couch...IDT recommendation: Re-educate staff r/t (related to) placing resident on couch after all meals. Th (sic) nurse is to assist</p>			

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	<p>the CNA with the transfer of the Resident from the wheelchair to the couch immediately following every meal.</p> <p>Fall #4 occurred on 8/3/15 at 7:40 (7:40 A.M.). "this nurse was called to the dining room by cna (name of CNA). Res noted to be lying on her right side on the floor in front of wheelchair. Res wheelchair was not near the dining room table and res had not yet been served her meal. When this nurse asked res what happened to cause her fall she stated "I don't know". Res was assessed and found to have no visible injuries..."</p> <p>A "Facility-Post Occurrence IDT and fall risk Assessment (DON or designee only)..." dated 8/3/15 at 10:17 A.M., read as follows: "...Resident found by CNA on right side on floor in dining room in front of her w/c, w/c was rolled back away from her....Root cause: w/c was not properly positioned where it would not roll away from table...IDT recommendations: when resident up in w/c for meals and positioned at table be sure wheels are locked so w/c will not roll back causing resident to slide out of chair..."</p> <p>Fall #5 occurred on 9/28/15 at 14:10 (2:10 P.M.). "...Fall with injury...4...Incident was unobserved. Staff</p>			

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	<p>member in nearby office heard small thud and went into dining area and found resident lying face down, mostly on the right side. When this RN asked what happened, resident stated, "I don't know, I just hurt." Resident had been toileted less than 20 minutes prior to being placed onto the couch by this RN and CNA..."</p> <p>A "Nursing-Transfer to hospital..." dated 9/28/15 at 14:19 (2:19P.M.) read as follows: "...h. Injury from occurrence... Resident (sic) fell from couch to floor, landing on forehead, causing laceration. Laceration on right hand. C/O 'complains of' pain in head and right arm. 5. USUAL PHYSICAL FUNCTIONING AND RISK ALERTS-PRIOR TO TRANSFER...a. Transfer ability...Extensive Assist...b. Bed Mobility...Extensive assist...g. Walking ability...Does not walk uses wheelchair...RISK ALERTS...Risk for falls..."</p> <p>A "Facility-Post Occurrence IDT and fall risk Assessment (DON or designee only)..." dated 9/29/15 at 12:09P.M., read as follows: "4...unaware of safety risk due to dementia...5. IDT recommendations: resident to be in w/c 'wheel chair' in common area when up..." Resident F was observed to be sitting on the couch</p>			

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
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	<p>on 10/27/15, 10/28/15 and 10/29/15.</p> <p>The ED (Emergency Department) Report dated 9/28/15 was provided by (Hospital Name) on 10/29/15 and read as follows: "...8 sutures placed...<u>FINAL IMPRESSION</u> 1. Acute closed head injury with laceration of face, status post fall..."</p> <p>During an interview with the DON on 10/29/15 at 11:20 A.M., the DON indicated Resident F was admitted on 3/14/14 with a right hip fracture due to a fall and therefore Resident F was automatically assessed to be at a high risk to fall and needed close supervision to prevent falls. The DON further indicated the Regional Vice President had discussed removing the wall between the nurses' stations and the lounge/restorative dining areas to increase the ability of the nurses to communicate with and supervise the residents while they were at their desks.</p> <p>3. During an observation on 10/27/15 at 12:45 P.M., CNA #14 took Resident G from the dining room to the resident's room. Upon entering Resident G's room, Resident G was observed in the bathroom sitting on the commode without a gait belt. CNA #14 walked with Resident G to the bed without the assistance of a</p>			

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	<p>walker and resident G was assisted to lie down.</p> <p>The clinical record of Resident G was reviewed on 10/28/15 at 10:30 P.M. The record indicated Resident G was admitted on 1/21/15 with diagnoses including, but not limited to, Alzheimer's disease.</p> <p>The undated "Nurse to CNA Report Sheet" provided by RN #2 on 10/27/15 at 10:15 A.M., read as follows for Resident G: "...Staff to get...up at 5am, toilet...and place...in lobby...Always amb (ambulate) with RW (rolling walker & (and) gait belt..."</p> <p>A "History and Physical Exam" form dated 1/22/15 was provided by the director of Nursing on 10/29/15 at 11:15 A.M., and it read as follows: "diagnosis: Fall with subdural Hematoma..."</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 4/28/15 indicated Resident G experienced severe cognitive impairment, required the assistance of 1 staff with transfers, was always incontinent and required the assistance of 1 staff for toileting.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 09/23/15 indicated Resident F experienced severe cognitive</p>			

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	<p>impairment for decision making and required the assistance of 2 staff for transfers and toileting.</p> <p>A Care Plan for falls dated 1/26/15 read as follows:</p> <p>"Fall Risk...Hx of fall, confusion/forgetfulness, weakness...requires staff physical support for transfers, unsteady gait...History of fracture of vertebrae..."</p> <p>"...Interventions/Tasks...Toilet before and after all meals...Date initiated 3/10/15... Get resident up @ (at) 5 a (A.M.) and place in lobby for closer supervision...Date initiated 4/12/15...Resolved 6/4/15... Offer toileting assistance at 5 am. Check resident and offer toilet assistance every 2 hours on odd hours...Date initiated 6/1/15... 7-22-15 always ambulate with a rolling walker and gait belt..."</p> <p>The "Nursing-Occurrence Initial assessment and the Facility-Post Occurrence IDT and fall risk Assessment..." was provided by MDS coordinator on 10/28/15 at 11:45 A.M., indicated Resident G fell on the following days:</p> <p>Fall #1 occurred on 3/10/15 at 13:30</p>			

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	<p>(1:30 P.M.). "...summoned to hall 2 dining room per CNA's. upon entering dining room observed resident lying on floor on right side...resident rubbing the back of head, stated she hit her head on the floor. resident unable to specify exactly where she was going or what she was planning on doing at the time of the fall...noted resident incontinent of b&b (bowel and bladder) ..."</p> <p>A "Facility-Post Occurrence IDT and fall risk Assessment (DON or designee only)..." dated 3/12/15 at 8:21 A.M., read as follows: "...Resident lying on floor in Hall 2 dining room on right side...unwitnessed fall...Resident has dx (diagnosis) of dementia and is unaware that she cannot be up by herself unassisted. resident was incontinent at time of fall... IDT recommendations: Resident to be toileted bere (sic) and/or after meals to prevent resident wanting to get up per self and toilet..."</p> <p>Fall #2 occurred on 3/14/15 at 12:00 (12:00 noon). "...Summoned to (room of resident F), upon entering observed resident on floor lying on right side...resident stated need to void..."</p> <p>A "Facility-Post Occurrence IDT and fall risk Assessment (DON or designee only)..." dated 3/16/15 at 8:51 A.M., read</p>						

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	<p>as follows: "...Root cause: Resident needing to toilet...Urine dip stick done since needing to toilet soon after being toiled..."</p> <p>Fall #3 occurred on 4/12/15 at 5:30 (5:30 A.M.) "Bed alarm went off and CNA and this RN went to room to find resident lying in floor on left side between bathroom and closet...Small hematoma left outer brow. 6 inch abrasion left back..."</p> <p>A "Facility-Post Occurrence IDT and fall risk Assessment (DON or designee only)..." dated 4/14/15 at 8:29 A.M., read as follows: "...Resident has dementia and is not cognitively aware that she cannot get up on her own for transfer/ambulation...IDT recommendation: Resident to be gotten up at 5A and placed in lobby for close supervision..."</p> <p>Fall #4 occurred on 5/31/15 at 05:20 (5:20 A.M.). "...Resident's bed alarm sounding alerting this nurse to room. Upon entering doorway a bang was heard by this nurse. Resident found in sitting position with back against the wall between bed and bedside cabinet. Resident was asked if she was in pain, resident stated, "I don't know, I think so, maybe". ...Resident toileted, changed and</p>			

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	<p>monitored."</p> <p>A "Facility-Post Occurrence IDT and fall risk Assessment (DON or designee only)..." dated 6/4/15 at 2:19 P.M., read as follows: "...Resident on floor between bed and nightstand in room. Resident noted to be incontinent at time...Root cause: resident had to go to the bathroom...IDT recommendations: Toileting plan changed to toilet every 2 hours while in bed on odd hours..."</p> <p>Fall #5 occurred on 7/22/15 at 20:30 (8:30 P.M.). "...Fall with injury...being escorted to bathroom with assistance of one. On entering bathroom resident tripped on feet and hit doorframe with left side of head. Small laceration bleeding, hematoma. Pressure applied with washrag. Left elbow with skin tear. 4 cm skin tear left elbow and 2 cm laceration left outer brow...Resident was sent to the ER for evaluation..."</p> <p>A "Facility-Post Occurrence IDT and fall risk Assessment (DON or designee only)..." dated 7/23/15 at 9:30 A.M., read as follows: "...Resident was being assisted per one staff member to bathroom...fell...hitting left side of head and left elbow...Root cause: unsteady gait...IDT recommendation: therapy to screen..."</p>			

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F 0371 SS=E Bldg. 00	<p>During an interview on 10/29/15 at 11:20 A.M., the Director of Nursing (DON) indicated Resident G was sent to the emergency room and steri strips were applied to laceration above left eyebrow. The DON further indicated Resident G had a history of a fall resulting in a fracture of vertebrae and was considered at high risk to fall at the time of admission to the facility.</p> <p>This Federal tag relates to Complaint IN00182360.</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure kitchen staff followed the facility's policy for personal hygiene related to nail grooming for 1 of 1 observation of the meal service.</p>	F 0371	<p>F371 E FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY</p> <p>It is the policy of Miller's Merry Manor, Rockport to serve food under sanitary conditions. It is</p>	11/20/2015

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	<p>Findings include:</p> <p>During an observation on 10/27/15 at 5:27 P.M., the evening shift cook was taking the temperature of the food located on the steam table. Her fingernails appeared to be long and artificial. During an interview at that time, she indicated she did not know what the policy was for grooming fingernails.</p> <p>During an interview on 10/27/15 at 5:52 P.M., the Administrator in Training indicated the evening shift cook's fingernails were not groomed according to the facility's policy. She further indicated the nail polish would be removed and that the artificial nails would be removed before she returned to work.</p> <p>The facility's policy for Personal Hygiene was provided on 10/27/15 at 5:52 P.M. and it read as follows: "...It is the policy that personnel follow correct sanitary guidelines related to personal hygiene...5. Fingernails should be kept short, clean and without polish. Artificial nails are not permitted..."</p> <p>This Federal tag relates to Complaint IN00181509.</p>		<p>the policy of Miller's Merry Manor, Rockport that dietary personnel follow correct sanitary guidelines related to personal hygiene.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> No resident was negatively impacted by the alleged deficient practice. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents are at risk to be affected by the alleged deficient practice. Dietary Manager is auditing dietary staff hygiene. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Dietary Manager will implement <u>Staff Hygiene QA tool</u> (Attachment N) 5 X a week X 4 weeks and monthly thereafter. <p>How the corrective action(s) will be monitored to ensure the</p>				

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	3.1-21(i)(2) 3.1-21(i)(3)		<p>deficient practice will not recur, i.e., quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · <u>Staff HygieneQA</u> tool (Attachment N) will be utilized by Dietary Manager or designee 5 X weekly X 4 weeks and monthly thereafter. · Any identified concerns will be corrected upon discovery, documented on facility QA tracking log, and reported during monthly QA Committee meeting overseen by the Administrator. 		