

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/20/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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F0000	<p>This visit was for Investigation of Complaint IN00102697.</p> <p>This visit was in conjunction with the the Post Survey Revisit (PSR) to the Investigation of Complaint IN00100626 completed on December 15, 2011.</p> <p>Complaint IN00102697 - Substantiated. Federal/state deficiencies related to the allegations are cited at F-328.</p> <p>Survey dates: January 19 and 20, 2012</p> <p>Facility number: 000018 Provider number: 155053 Aim number: 100273930</p> <p>Survey team: Sharon Lasher RN, TC Angel Tomlinson RN</p> <p>Census bed type: SNF: 8 SNF/NF: 61 Residential: 16 Total: 85</p> <p>Census bed type: Medicare: 4 Medicaid: 52</p>	F0000		

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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	<p>Other: 29 Total: 85</p> <p>Sample: 4</p> <p>This deficiency also reflects a state finding cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 1/25/12 by Jennie Bartelt, RN.</p>			
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F0328 SS=D	<p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff suctioned a non-verbal resident who was experiencing gurgling and wet breath sounds on inspiration and expiration in a timely manner and failed to empty the 3/4 full suction canister. The deficient practice affected 1 of 1 resident reviewed for suctioning in a sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 1/19/12 at 10:40 a.m. Resident #A's diagnoses included, but were not limited to, anoxic (deficiency of oxygen) brain damage, closed dislocation first cervical vertebra and quadriplegia.</p> <p>Resident #A's (MDS) Minimum Data Set, assessment, dated 10/26/11, indicated the following: - speech clarity, no speech - makes self understood, rarely/never</p>	F0328	<p>Resident #A was suctioned by a Licensed nurse and the suction canister was changed. Assessment of resident to be completed for need to be suctioned with each interaction with resident #A. The C.N.A.'s have been instructed to tell the nurse if they hear the resident gurgling or have any concerns with resident or if resident #A's family have specifically asked that the resident be suctioned. The family has been asked to tell the nurse that they would like the resident assessed for the need to be suctioned. The family of resident #A has been asked to turn on the call light if they feel resident # A needs assistance or assessment in any way. The assessment and documentation will be completed by a Licensed Nurse. Visual and auditory monitoring via camera and sound monitor offered to Resident #A's family to ensure continual sight and sound monitoring of Resident #A's status; Resident #A's family refused these services. The staff</p>		02/10/2012		

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	<p>understood</p> <ul style="list-style-type: none"> - ability to understand others, sometimes understands - transfer, total dependence - walk in room or corridor, activity did not occur - respiratory treatments, suctioning <p>1. Resident #A's physician's recapitulation orders dated 1/12, indicated, "Tracheotomy (opening in the neck through the trachea to provide an airway), deep suction as needed"</p> <p>On 1/20/12 from 10:00 a.m. to 10:40 a.m., Resident #A was observed in bed with gurgling and wet sounding respiration with every inspiration and expiration.</p> <p>During interview on 1/20/12 at 10:00 a.m., a family member indicated two CNAs were asked at 9:30 a.m. to inform the nurse Resident #A needed to be suctioned.</p> <p>On 1/20/12 at 10:40 a.m., Staff LPN #3 was asked to suction Resident #A.</p> <p>On 1/20/12 at 10:45 a.m., Staff LPN #3 was observed suctioning Resident #A three times per tracheotomy tube. During interview at this time, Staff LPN #3 indicated she obtained a moderate amount of respiratory secretions.</p>		<p>LPN #3 has been educated and disciplined on the importance of promptly assessing the resident and suctioning as necessary. LPN #3 has been educated on the facility Policy and Procedure-Suctioning Procedures. See Attachment #1 Disciplinary form. No other residents were affected by this deficient practice as no other residents have a tracheostomy at this time. Nursing staff inservice to be held on 2.7.12 to re-educate staff on the Policy and Procedure for Suctioning Procedures by a Respiratory Therapist. See Attachment #2 "Suctioning Procedures" Nursing staff have been informed that failure to comply with the procedures for assessing and suctioning will be subject to disciplinary action once the re-education has been completed. Corrective action will be QA monitored using the Suctioning monitoring review audit tool. This QA tool will be used by the DON or Designee daily x 1 week, then weekly x 4 weeks, then monthly x 6 months to ensure residents requiring suctioning receive timely respiratory assessments, suctioning and suction machine maintenance. This process will be monitored using the Quality Improvement tool. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented. See Attachment #3</p>				

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	<p>On 1/20/12 from 10:50 a.m. to 11:15 a.m., with continual observation, Resident #A no longer had gurgling or wet sounding respirations.</p> <p>During interview on 1/20/12 at 11:20 a.m., Staff CNA #1 indicated Resident #A's family asked her to inform the nurse that Resident #A needed suctioned, and she notified staff LPN #3 of the family's request. Staff CNA #1 also indicated it was not unusual for Staff LPN #3 to wait an hour or more before she checked or suctioned Resident #A after she was informed of the family's request for Resident #A to be suctioned.</p> <p>During interview on 1/20/12 at 11:30 a.m., Staff CNA #2 indicated she was aware Resident #A's family had requested for Resident #A to be suctioned at 9:30 a.m. this morning, and that Staff LPN #3 was advised of the family's request to suction Resident #A. Staff CNA #2 also indicated Staff LPN #3 had not suctioned Resident #A since the request, but it was not unusual for Staff LPN #3 to wait an hour or more before checking on or suctioning Resident #A.</p> <p>2. On 1/19/12 at 10:30 a.m., Resident #A's suction canister was observed over 1/2 full of secretions.</p>		"Suctioning Monitoring Review" Q.A. Tool.		

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	<p>On 1/20/12 at 10:45 a.m., Staff LPN #3 was observed suctioning Resident #A. The suction canister was 3/4 full.</p> <p>During interview on 1/20/12 at 10:48 a.m., Resident #A's family member indicated Resident #A's suction canister had not been emptied for several days and was beginning to get full.</p> <p>During interview on 1/20/12 at 10:50 a.m., when queried when the suction canister would be emptied, Staff LPN #3 stated, "When it gets full."</p> <p>A document titled "Suctioning Procedures," dated 6/28/06, provided by the DON (Director of Nursing) on 1/20/12 at 9:40 a.m., and indicated by the DON to be the most current policy, indicated, "Care of suction equipment, suction canisters and tubing must be emptied and rinsed each shift and changed daily."</p> <p>This deficiency was cited on 12/15/2011. The facility failed to implement a system plan of correction to prevent recurrence.</p> <p>This federal tag relates to Complaint IN00102697.</p> <p>3.1-47(a)(5)</p>						

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