

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  04/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Investigation of Complaints IN00126622 and IN00127078.</p> <p>Complaint IN00126622 - -Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00127078 -- Substantiated. Federal/state deficiency related to the allegations is cited at F441.</p> <p>Survey dates: April 26, 29 and 30, 2013</p> <p>Facility number: 000018 Provider number: 155053 AIM number: 100273930</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 14 SNF/NF: 42 Residential: 18 Total: 74</p> <p>Census payor type: Medicare: 12 Medicaid: 39 Other: 23 Total: 74</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.

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  04/30/2013
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 5/01/13 by Suzanne Williams, RN</p>				

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  04/30/2013	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000441	We respectfully request PAPER COMPLIANCE in order to correct	05/10/2013			

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  04/30/2013	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>ensure hand hygiene was utilized by a staff member during the care of a resident's tracheostomy for 1 of 3 residents reviewed for ADL (activities of daily living) care in a sample of 3. (Resident #B, LPN #1)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 4-29-13 at 8:45 a.m. Her diagnoses included, but were not limited to, anoxic brain damage, history of pneumonia, tracheostomy and quadriplegia.</p> <p>A care observation of Resident #B's tracheostomy was conducted on 4-29-13 at 11:06 a.m. with LPN #1. A physician's order indicated tracheostomy care of changing the tracheostomy collar daily and as needed and to clean the inner cannula of the tracheostomy each shift and as needed. LPN #1 entered the room and began to assemble the necessary supplies. Hand hygiene was not observed prior to obtaining and opening the supplies for the tracheostomy care, nor prior to donning the gloves in the supply kit. After removing the inner cannula, passy muir (device for the end of the tracheostomy tube), dressing around the tracheostomy stoma and</p>		<p>this deficient practice. LPN #1 was re-educated on the Policy and Procedure for Hand Washing (Attachment #1), Use of Medical Gloves (Attachment #2) and Tracheostomy Care (Attachment #3). No other residents were affected by this deficient practice. Resident #B is the only resident currently at the facility requiring tracheostomy care. No other residents have the potential to be affected by this deficient practice. All staff were re-educated on 5.7.13 (Attachment # 4) on the Policy and Procedure for Hand Washing (Attachment #5) and Use of Medical Gloves (Attachment #6). Random observation of hand washing and glove application/removal was completed. (Attachment #7). Corrective action will be QA monitored using the Hand Washing and Glove application/removal audit tool. (Attachment #8). This QA tool will be used by the DON or designee daily x 1 week, weekly x 4 weeks and monthly x 6 months to ensure resident's requiring tracheostomy care receive proper tracheostomy care including appropriate use of gloves and hand washing. This tool will also be used for observations of all staff to ensure proper hand washing and glove use occurs. This process will be monitored using the Quality Improvement audit tool Hand Washing and Glove application/removal. The</p>				

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  04/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>loosening the tracheostomy collar, the gloves were removed. Hand hygiene was not observed to be performed prior to donning a new pair of gloves prior to suctioning the resident's tracheostomy. After removal of the gloves, handwashing was performed prior to application of a new pair of gloves prior to cleansing the inner cannula and re-insertion of the inner cannula into the tracheostomy, followed by replacement of the tracheostomy collar to secure the tracheostomy in place, cleansing of the stoma and replacement of a new dressing around the stoma. Upon removal of the gloves, hand hygiene was not observed. The resident then requested to be suctioned again. LPN #1 was observed to obtain the needed supplies without hand hygiene being conducted prior to donning of a new pair of gloves and suctioning of the resident. Upon removal of the gloves, hand hygiene was not observed prior to LPN #1 exiting the resident's room.</p> <p>In interview with LPN #1 on 4-29-13 at 3:15 p.m., she indicated she had used hand sanitizer prior to entering Resident #B's room for the tracheostomy care. She indicated at the time of the tracheostomy care with Resident #B, she indicated she</p>		<p>results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented. Date of completion 5.10.13</p>	

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  04/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was very disorganized and should have had all of the needed supplies readily available.</p> <p>On 4-29-13 at 2:10 p.m., the Director of Nursing provided a copy of a policy entitled, "Use of Medical Gloves (application and removal)." This policy indicated, "...Gloves should not be used as a substitute for hand-washing...Hands should be washed initially prior to putting on gloves...Gloves should be removed and hands washed with soap and water immediately after glove removal...Gloves should be removed and hands washed between care activities with patients...In no way does glove use modify hand hygiene indications or replace hand hygiene by washing with soap and water or hand rubbing with an alcohol-based hand rub."</p> <p>This Federal tag relates to Complaint IN00127078.</p> <p>3.1-18(l)</p>			