

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155557	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00150404.</p> <p>Complaint IN00150404 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00151393.</p> <p>Survey dates: June 25, 26, 27, 30 and July 1, and 2, 2014</p> <p>Facility number: 000500 Provider number: 155557 AIM number: 100266220</p> <p>Survey team: Karina Gates, Generalist-TC Courtney Mujic, RN (June 25 and 26, 2014) Beth Walsh, RN Tom Stauss, RN</p> <p>Census bed type: SNF: 20 SNF/NF: 51 Total: 71</p> <p>Census payor type:</p>	F000000	<p>July 17, 2014 Kim Rhoades Director, Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Survey Event ID KBEK11 Dear Ms. Rhoades: Please accept the enclosed plan of correction as credible allegation of compliance to the deficiencies cited during our Annual Health Survey conducted on May 2, 2013 at Miller's Merry Manor, in Indianapolis. Hopefully, you will find that our remedies are both sufficient and thoroughly explained in providing you a clear picture of how we corrected these concerns. With this submission of these remedies, we are requesting paper compliance. If, after reviewing our plan of correction, you have any questions or require further information, please do not hesitate to contact me at your convenience at (317) 357-8040. Respectfully submitted, Paula Juday Administrator</p>	
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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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F000280 SS=D	<p>Medicare: 18 Medicaid: 40 Other: 13 Total: 71</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on July 07, 2014; by Kimberly Perigo, RN.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal</p>			

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	<p>representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise a ROM/ADL (Range of Motion/Activities of Daily Living) care plan with an intervention of a splint to be worn daily, as tolerated, and to update a care plan for pressure ulcer wounds for 2 of 21 residents reviewed for care plans. (Resident #C and #33).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #33 was reviewed 06/27/14 at 10:45 a.m. The diagnoses for Resident #33 included, but were not limited to, flaccid hemiplegia affecting dominant side, polyneuropathy in diabetes, and acute but ill defined cerebrovascular disease.</p> <p>A review of the June 2014 Physician's Order indicated an order for a "carrot splint" to be on as tolerated when up in chair, off for care and as needed. The Physician's Orders indicated the order was initiated on 7/15/13.</p> <p>A Passive Range of Motion care plan, dated 6/11/14, and ADL care plan, dated 3/23/07, did not indicate an intervention for a "carrot splint." Both care plans remained current at the time of review.</p>	F000280	<p>F280 RIGHT TO PARTICIPATE IN PLANNING CARE – PLAN REVISE CP It is the policy of this facility to revise care plans daily and PRN as changes in the resident's condition dictate. To correct this deficiency: 1. Resident #33's care plan was reviewed and updated to reflect "carrot splint" as an intervention on 7/1/14. 2. Resident #C has discharged. All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected: · 100% of residents with orders for splints will be audited and reviewed to ensure care plan reflects interventions for splints on or before 7/31/14 · 100% of residents with pressure areas will be audited and reviewed to ensure care plan interventions are specific to turning & repositioning on or before 7/31/14 To prevent recurrence: · All nurses will be in-services on or before 7/31/14 on the policy and procedure for Care Plan Development & Review · All nurses will be in-services on or before 7/31/14 on the policy and procedure for Skin Management Program · The DON or Designee will monitor compliance using the QA Tool titled "Care Plan" daily X30 days, weekly X4, monthly X3, and quarterly thereafter. This QA Tool will be</p>	07/31/2014

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	<p>During an interview with the Director of Nursing (DoN), on 7/1/14 at 9:50 a.m., she indicated if any type of device or splint was ordered for a resident, the splint/device should be an intervention on a ROM/ADL care plan.</p> <p>On 7/1/14, at 3:00 p.m., the DoN indicated the ADL care plan was updated to include the "carrot splint" as an intervention.</p> <p>2. Resident #C's record was reviewed on 6/27/14 at 11:10 a.m. The resident's diagnoses included, but were not limited to, unspecified septicemia, atherosclerosis, peripheral vascular disease, urinary incontinence, fecal incontinence, ulcer of heel and midfoot, anemia, cardiomyopathy, and congestive heart failure. The resident's medications included, but were not limited to, Lasix, metoprolol, ferrous sulfate, omeprazole, hydrocodone, MiraLax, senna, lisinopril, Synthroid, and simvastatin.</p> <p>An MDS (Minimum Data Set) admission assessment, dated 3/28/14, indicated Resident #C was at risk for the development of pressure ulcers.</p> <p>A wound assessment, dated 6/10/14, indicated a "...NEW WOUND..." and the wound description identified the location</p>		<p>started on or before 7/31/14. <i>Attachments: Care Plan Development & Review Policy and Procedure (1-A), Skin Management Program (1-B), QA Tool "Care Plan" (1-C) .</i></p>				

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	<p>of the wound as the left and right buttocks of Resident #C. The assessment indicated, "...Turn and reposition every 2 hours while in bed..." as an intervention to treat the new wound.</p> <p>A physician's order, dated 6/18/14, indicated for nursing staff to cleanse Resident #C's right and left buttock wounds, apply Santyl (a wound medication), and a dry dressing daily.</p> <p>Wound care plans and a skin risk care plan, dated 3/21/14, indicated nursing staff to monitor wounds for signs of infection, wound care team to follow, administer treatments as ordered, monitor labs, administer pain medication, and nutritional interventions. No intervention was listed on the wound care plans to turn and reposition Resident #C.</p> <p>On 7/2/14 at 1:09 p.m., the MDS Coordinator indicated one of various interventions used by nursing staff to prevent skin breakdown is turning and repositioning.</p> <p>On 7/2/14 at 1:41 p.m., during an interview, the DON indicated Resident #C's wound care plan should have been updated with an intervention to turn and reposition the resident every two hours and as needed. She indicated any</p>			

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F000309 SS=G	<p>resident with limited mobility who has pressure areas or who is at risk for skin breakdown should have the intervention of "turn and reposition" every 2 hours.</p> <p>3.1-35(d)(2)(B)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to follow up on a recommendation for an increase in a pain medication and timely address a resident's pain resulting in sleeplessness and varied participation and progress in therapy, and for 1 of 3 residents reviewed of 3 who met the criteria for pain. (Resident #9)</p> <p>Findings include:</p> <p>The clinical record for Resident #9 was reviewed on 7/1/14 at 10:30 a.m. The diagnoses for Resident #9 included, but were not limited to: osteoarthritis, gout, bilateral leg pain, hiatal hernia, peripheral neuropathy, stage 3 pressure ulcer,</p>	F000309	<p>F309 – PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>It is the intent of this facility to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>1. Resident #9's recommendation for an increase in pain medication was completed on 7/1/14.</p> <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents</p>	07/31/2014

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	<p>arterial ulcer, and mouth pain.</p> <p>The July, 2014 Physician's Orders, printed 6/26/14, indicated Resident #9 was prescribed the following medications for pain: duloxetine (antidepressant) 60 mg once daily effective 5/28/14, diclofenac topical 1% gel to be applied to left thigh 4 times daily effective 6/6/14, gabapentin 600 mg tab to be given 3 times daily effective 6/12/14, hydrocodone with acetaminophen 5-325 mg tab to be given every 4 hours as needed for moderate to severe pain effective 6/17/14, and tramadol 37.5 mg with acetaminophen 325 mg tab to be given every 6 hours as need for pain effective 4/3/14.</p> <p>The 4/2/14 pain care plan for Resident #9 indicated the goal was, "Pain will be controlled to acceptable level." Interventions indicated on the care plan were to monitor the effectiveness of pain medications, to notify M.D. as needed, and to acknowledge the presence of pain and discomfort, and to listen to the resident's concerns.</p> <p>An interview was conducted with Resident #9 on 6/26/14 at 1:18 p.m. regarding whether he had any discomfort such as pain, heaviness, burning, or hurting with no relief. Resident #9</p>		<p>are not affected:</p> <ul style="list-style-type: none"> 100% of residents who have had appointments outside of this facility within the last 30 days will be audited and reviewed to ensure all recommendations were noted to have follow up as indicated on or before 7/31/14 <p>To prevent recurrence:</p> <ul style="list-style-type: none"> All nurses will be in-services on or before 7/31/14 on the policy and procedure for "Nursing – Outpatient/ER Services Return Assessment. The DON or Designee will monitor compliance using the QA Tool titled "Outpatient Recommendations" daily X30 days, weekly X4, monthly X3. This QA Tool will be started on or before 7/31/14. <p><i>Attachments: Nursing – Outpatient/ER Services Return Assessment Policy and Procedure (2-A), QA Tool "Outpatient Recommendations" (2-B) .</i></p> <p>IDR F309 is being disputed Provide Care/Services for highest well being Miller's Merry Manor of Indianapolis East respectfully requests that F309 SS=G be deleted from the annual survey of July 2, 2014 or at a</p>	

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	<p>indicated, "My right foot burns all the time. I need my pain meds (medications) adjusted. If I took the pain meds at the right time, I could walk back from therapy. During the night, I'm in so much pain, and they say it's in between times for me to take it, so I can't get it. I pray to God to take the pain away. It's driving me out of my skull. This has been going on for quite a while...."</p> <p>An interview was conducted with PTA (Physical Therapy Assistant) #3 on 7/2/14 at 9:56 a.m. regarding Resident #9's progress with therapy. He indicated, "It's been widely variable. With his wounds on his foot, he may not walk at all. Last week he didn't walk on it at all."</p> <p>The 4/2/14 Physical Therapy (PT) Plan of Care for Resident #9 indicated the long term goals were, "The patient will safely ambulate up/down 12 of (sic) steps with hand rail with independent (able to negotiate stairs without physical assistance and/or cues. No handrails, assistive device, or external support required.) to enter/exit home. The patient will complete all functional transfers with independent (able to transfer without physical assistance or verbal cues. No external support or assistive device required.) and ambulation x 300 feet with can with</p>		<p>minimum be reduced in scope and severity . It was stated that based on observation, interview and record review the facility failed to follow up on a recommendation for an increase in a pain medication and timely address a resident's pain resulting in sleeplessness and varied participation and progress in therapy.</p> <p>The diagnosis for resident #9 include: Dementia with Lewy Body, Osteoarthritis, gout, bilateral leg pain, hiatal hernia, peripheral neuropathy, stage 3 pressure ulcer, arterial ulcer, and mouth pain. Changes in resident's pain regiment occurred as follows (Attachment IDR 1):</p> <ul style="list-style-type: none"> · 4/1/14 resident admitted to facility with: TRAMADOL 37.5MG WITH ACETAMINOPHEN 325MG TABLET (ULTRACET) · 4/9/14 Neurontin 200MG po daily @ 8PM – peripheral neuropathy · 4/17/14 Stop allopurinol; start Uloric 40MG – gout · 4/24/14 Increase Neurontin to 200MG po TID DX: neuropathy pain · 5/8/14 Start Mary Magic Mouthwash 10cc po QID X 5 days for sore mouth · 5/8/14 Increase Neurontin to 300MG po TID · 5/13/14 Start Cymbalta 30MG po daily @8Am – pain · 5/20/14 Increase Neurontin to 400MG po TID 	

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	<p>modified independence." The PT plan indicated the reason for referral was, "Recent hospitalization resulting in a decrease in strength, balance, endurance, safety, and mobility." The therapy necessity was, "Therapy necessary for improved strength, balance, endurance, safety, and mobility. Without therapy patient at risk for decreased functional..."</p> <p>The 6/25/14 PT Therapist Progress Note indicated, "Analysis of Functional Outcome/Clinical Impression: Patient has demonstrated inconsistent gains in therapy due to pain and fatigue....Impact on Burden of Care/Daily Life: complicating factors, including pain and increased fatigue may prevent the patient from achieving all established goals."</p> <p>The 4/2/14 Occupational Therapy Plan of Care indicated, "Patient is on medication for the following diagnoses which could impact participation and tolerance with therapy: gout,...pain." the therapy plan indicated the pain intensity on a scale of 0-10 was "2/10." The therapy plan indicated, "underlying Impairments: Activity Tolerance, Standing - (symbol for "about") 2 minutes Pain in B (both) legs....The patient actively participates in 2 minutes of graded therapeutic activities influenced by fatigue, pain, nausea and decreased functional activity tolerance."</p>		<ul style="list-style-type: none"> · 5/20/14 Start DICLOFENAC TOPICAL 1% GEL (VOLTAREN GEL) · 5/28/14 Increase Cymbalta for 60MG po daily – neuropathy · 6/12/14 Increase Neurontin to 600MG po TID · 6/15/14 Start Norco 5/325MG po Q 4hrs PRN · 6/20/14 Resident was seen at Wound Care Center with new orders per: Dr. Williams with no changes to pain meds · 6/26/14 Resident was seen in facility by Dr. Williams with pain addressed and no increase in pain meds · 6/27/14 Resident was seen at Wound Care Center with new orders per: Dr. Williams with no changes to pain meds · 7/1/14 Resident was seen in facility by Dr. Christianberry, with review of pain and no changes to pain meds <p>In addition to these changes to resident's pain regiment the following information is pertinent: The 4/2/14 pain care plan for Resident #9 indicated the goal was, "Pain will be controlled to acceptable level." Interventions indicated on the care plan were to monitor the effectiveness of pain medications, to notify M.D. as needed, and to acknowledge the presence of pain and discomfort, and to listen to the resident's concerns. All of these care plan interventions were achieved as</p>	

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	<p>The 5/27/14 OT (Occupational Therapy) Therapist Note indicated, "Caregiver education continued with patient regarding attempting to complete with functional tasks and participating despite pain and fatigue. Remaining Functional Deficits/Underlying Impairments: Patient continues to have deficits in functional activity tolerance and standing tolerance which limit ability to safely and independently complete self care tasks."</p> <p>The 5/28/14 OT Therapist Progress & Updated Plan of Care note indicated, "Caregiver education continued with patient regarding attempting to complete with functional tasks and participating despite pain and fatigue....Remaining Functional Deficits/Underlying Impairments: Patient continues to have deficits in functional activity tolerance and standing tolerance which limit ability to safely and independently complete self care tasks."</p> <p>The 6/11/14 OT Therapist Progress note indicated, "Patient continue (sic) to present with c/o (complaints of) LE (lower extremity)/foot pain impacting standing tolerance/balance....Higher level challenges introduced this week in sustained UE (upper extremity) activity and standing time....Patient/Caregiver</p>		<p>evidenced by: the pain flow sheets in which pain medications were administered and assessed for effectiveness (Attachment IDR-2); and notification of the MD as evidenced by the above changes to pain regiment.</p> <p>An interview with Resident #9 on 6/26/14 indicated that "During the night, I'm in so much pain, and they say it's in between times for me to take it, so I can't get it." Resident #9's nursing assessment completed on 6/26/14 at 12:48AM indicated no reports of pain (Attachment IDR-3); resident had no requests of pain medication during the night of 6/25/14 or 6/26/14 according to pain flow sheet (Attachment IDR-2). Also included are the notes from psychiatric services dated 5/30/14, where resident reports, "I sleep very sound" (Attachment IDR-4). According to PHQ-9 assessments completed by Social Services on 4/27/14, 5/27/14, and 6/26/14, Resident #9 has no reports of "Trouble falling or staying asleep, or sleeping too much." (Attachment IDR-5)</p> <p>Regarding resident's participation in therapy services, the following information is provided using the documentation provided during the audit (Attachment IDR-6):</p> <ul style="list-style-type: none"> 4/2/14 Occupational Therapy Plan of Care was completed at Resident #9 admission to the facility, which indicated he was able to participate in only 2 minutes of 	

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	<p>Training: Caregiver education continued with patient regarding importance of continued attempts at participation with functional tasks to improve safety and independence. Patient continues to c/o LE pain...Impact on Burden of Care/Daily Life: The patient's set backs in standing tolerance and functional activity tolerance due to LE pain, have caused in increase in burden of care for bathing, dressing and toileting."</p> <p>The 6/25/14 OT Therapist Progress note indicated, "Patient continues to have deficits in standing tolerance/balance and functional activity tolerance which limit ability to safely complete self care and functional transfer tasks."</p> <p>The June, 2014 PRN Pain Management Flow Sheet for Resident #9 was reviewed. It indicated prn tramadol was only given four times between the hours of 7:00 a.m. and 9:00 a.m. when it would have been most effective during therapy, from 6/1/14 to 6/28/14. It indicated prn hydrocodone was never given between 7:00 a.m. and 9:00 a.m., and only given three times between 6/1/14 and 6/28/14.</p> <p>An interview was conducted with Unit Manager #2 on 7/2/14 at 2:25 p.m. regarding Resident #9's pain during therapy. She indicated, "Therapy never</p>		<p>graded therapeutic activities, with a goal of 15 minutes of participation</p> <ul style="list-style-type: none"> · 5/27/14 Occupational Therapy Progress Note indicates resident is able to participate in 10-12 minutes of graded therapeutic activities · 5/28/14 Occupational Therapy Progress Note indicates resident is able to participate in 12 minutes of graded therapeutic activities · 6/11/14 Occupational Therapy Progress Note indicates resident is able to participate in 10-15 minutes of graded therapeutic activities. Higher level challenges introduced this week in sustained UE activity and standing time. · 6/25/14 Occupational Therapy Progress Note indicates resident goal is met. He is able to participate in 15-20 minutes of graded therapeutic activities with higher level challenges. Patient has progressed in standing balance / tolerance and is not longer dependent upon caregiver for as much assist with toileting tasks. <p>The June, 2014 PRN Pain Management Flow Sheet for Resident #9 was reviewed. On the following dates Tramadol was administered in the morning, and reported by Resident #9 to be effective between the hours of 6AM and 9AM (thus indicating there would not be a need for further medications) (Attachment IDR-2): 6/1/14 – 0 pain reported at 6AM</p>	

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218
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	<p>told me about him having foot pain during his therapy. He usually goes to therapy right after breakfast, so around 8:45 a.m., maybe a little later. His tramadol is only prn every 6 hours, so if he gets it in the middle of the night, he can't have it an hour before therapy for it be at it's most effective. He takes neurontin, but that's not really going to do much as far as pain." She indicated she did not know why Resident #9 was not on regularly scheduled pain medications. She offered no information regarding the prn hydrocodone as an option prior to therapy.</p> <p>During an interview with PTA (Physical Therapy Assistant) #3 on 7/2/14 at 9:56 a.m., he indicated, "This week he went 150 feet. He's improving this week. At first he was improving, then not so much....He comes five times a week. He's never refused, always comes, and does something. As of right now he can bear weight, and can transfer with a stand by. When we started, he was a minimal assist, so he has improved. Right now, he's as good as he's been."</p> <p>The June, 2014 PRN Pain Management Flow Sheet for Resident #9 indicated on 6/29/14, Resident #9 received tramadol at 7:30 a.m., hydrocodone at 10:45 a.m., tramadol at 2:30 p.m., hydrocodone at</p>		<p>6/2/14 – 0 pain reported at 6AM 6/3/14 – 0 pain reported at 6AM 6/4/14 – 0 pain reported at 6AM 6/5/14 – 0 pain reported at 6AM 6/7/14 – 0 pain reported at 5:30AM 6/11/14 – received at 9AM 6/12/14 – 0 pain reported at 7AM 6/13/14 – 0 pain reported at 6AM 6/14/14 – received at 9AM 6/17/14 – 0 pain reported at 6AM 6/19/14 – 0 pain reported at 6AM 6/20/14 – 0 pain reported at 5AM 6/22/14 – 0 pain reported at 7AM 6/24/14 – 1 / 10 pain reported at 7AM 6/25/14 – 0 pain reported at 6AM 6/27/14 – received at 9AM 6/28/14 – 0 pain reported at 6AM 6/29/14 – received at 7:30 AM 6/30/14 – received at 8:00 AM</p> <p>In addition, the hydrocodone was never given between 7:00AM and 9:00AM, and only given three times between 6/1/14 and 6/28/14. The order for Hydrocodone PRN was not received until 6/15/14 (Attachment IDR-7) and was received for moderate to severe pain. According to the PRN Pain Management Flow Sheet from 6/15/14 to 6/30/14 (during the time that resident has order for PRN Hydrocodone), Resident #9 received PRN Hydrocodone when the PRN Tramadol was not effective in controlling his pain. On the dates of 6/15/14 and 6/29/14 Resident #9 reported his pain level at a 10, indicating severe pain. One these</p>	

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	<p>3:30 p.m., and tramadol at 8:30 p.m.</p> <p>The 6/27/14 Wound Care Center note indicated Resident #9 had a stage 3 pressure ulcer on his right heel, an arterial ulcer midfoot, and atherosclerosis of native arteries of the extremities with gangrene. The note indicated, "My Reported Pain Level (Last Filed) Score 10-Excruciating (worst ever) Location Foot-right Comments pt (patient) states he takes pain medication as prescribed....Recommend increasing Gabapentin to 900 mg PO (by mouth) TID (3 times daily) r/t (related to) pain 10/10."</p> <p>An interview was conducted with the DON (Director of Nursing) on 7/1/14 at 3:18 p.m. regarding whether the recommendation from the wound care center to increase gabapentin was addressed. She indicated she did not see an order to increase it or any information to suggest the recommendation was acknowledged. She indicated it was the nurse's responsibility to act on the recommendation. The nurse, she indicated as having been responsible, was Unit Manager #2.</p> <p>An interview was conducted with Unit Manager #2 on 7/1/14 at 3:35 p.m. She indicated, "I didn't see anything about a</p>		<p>dates, the PRN Tramadol was given, reported to not be effective, and then the PRN Hydrocodone was given. On all other dates, Tramadol PRN was effective in managing pain to an acceptable level for Resident #9. According to nursing assessments completed on day shift resident pain level during assessments ranged from 0-3 during assessments, with Tramadol given as ordered with relief (Attachment IDR-8).</p> <p>An interview conducted with Unit Manager #2 regarding Resident #9's pain during therapy. Resident's pain medications have been adjusted as documented above. Resident does have routine pain medications including: Neurotin and Cymbalta. These medications are prescribed for Resident #9 for pain which are both appropriate uses for neuropathic pain according to the drug monographs for both medications (Attachment IDR-9). The 6/27/14 Wound Care Center note recommended increasing Gabapentin to 900 mg PR TID r/t pain 10/10. According to Nursing – Outpatient /ER Services Return Assessment (Attachment IDR-10), Resident #9 returned to facility from his appointment at 12:00PM. Resident #9 had Tramadol PRN at 9AM and 4:30PM, both of which he indicated were effective in controlling his pain according to PRN Pain Management Flow Sheet (Attachment IDR-2). The</p>	

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	<p>recommendation for increase in gabapentin to 900 mg TID." At this time, Unit Manager #2 reviewed the 6/27/14 wound care center notes for Resident #9, and stated, "No, I didn't see that."</p> <p>The Pain Management Program policy provided by the DON on 6/30/14 at 3:30 p.m. indicated, "It is the goal of this facility to assist residents in achieving their optimal level of comfort by providing an effective pain management program."</p> <p>3.1-37(a)</p>		<p>Gabapentin increase was not listed under the "Start taking" orders on page 2/5 of the report from CHE Wound Care, but was instead listed under "My Provider's Instructions" on page 3/5 as a recommendation r/t pain 10/10 (Attachment IDR-11). No order was given from the Wound Care Center for this increase. The return assessment was completed by the floor nurse, Krystin Graham, LPN, who assessed Resident #9's pain to be 0 upon his return, updated the attending physician upon Resident #9's return to the facility (Attachment IDR-11) with no new order to increase Gabapentin. New wound care orders were obtained on 6/27/14 from the physician, according to Wound Care Center recommendations, following Resident #9's return from the appointment (Attachment IDR-12). The Pain Management Program policy indicates it is the goal of this facility to assist residents in achieving their optimal level of comfort. Resident #9 has a diagnosis of Lewy Body Dementia. His reports of pain are often inconsistent, which may be a characteristic of Lewy Body Dementia according to the Lewy Body Dementia Association (Attachment IDR-13). We feel that the citation was unwarranted as it did not allow for or take into consideration that the nursing staff had been addressing Resident #9's pain according to his</p>	

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p>		<p>plan of care.</p> <p>We feel that we have shown through this information presented that Resident #9 did not experience sleeplessness and did show progress in therapy. We also feel that the facility did follow up on the recommendation for an increase in a pain medication and that the facility did timely address a resident's pain. Thank you for your consideration in this manner.</p>	

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	<p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to provide medication in a sanitary manner for 1 of 6 residents reviewed for medication administration (Resident #43)</p> <p>Findings include:</p> <p>During a medication administration observation of RN #1, on 6/30/14 at 11:43 a.m., RN #1 popped Resident #43's medication (Percocet 5/325 milligrams-Pain Medication) out of the medication punchcard. The pill flew on to the medication cart surface, next to the Medication Administration Record book and the pill crusher. RN #1 put on gloves and retrieved the pill from the top of the Medication Cart, crushed the medication, and placed the medication in applesauce. RN #1 then administered the medication to Resident #43. Medication Administration Observation was done</p>	F000441	<p>F441 – INFECTION CONTROL, PREVENT, SPREAD It is the policy of this facility to administer medications following infection control. 1. RN#1 was educated on infection control as it relates to medication administration in a sanitary manner on 7/17/14. All residents are at risk to be affected by this deficient practice.</p> <p>To prevent recurrence: · All nurses will be in-services on or before 7/31/14 on the policy and procedure for “Medication Administration specific to cleaning of med cart”. · The DON or Designee will monitor compliance using the QA Tool titled “Medication Administration” daily X30 days, weekly X4, monthly X3, and quarterly thereafter. This QA Tool will be started on or before 7/31/14. <i>Attachments: Nursing –Medication Administration Policy and Procedure (3-A), QA Tool “Medication Administrations” (3-B)</i></p>	07/31/2014

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	<p>consistently with RN #1 till 12:25 p.m. During the entire observation, RN #1 did not clean or wipe down the medication cart and the medication cart was not observed to be cleaned/wiped down prior to the medication administration observation.</p> <p>During an interview with the Director of Nursing (DoN), on 6/30/14 at 2:30 p.m., she indicated medication that touched the medication cart, should not be administered to Residents.</p> <p>On 7/2/14, at 10:10 a.m., the DoN indicated the medication should not have been given to Resident #43, since the medication touched the medication cart, where other objects were laying on the cart and it can be considered an infection control issue.</p>			