

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 05/02/2013
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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.</p> <p>Survey dates: April 23, 2013-May 2, 2013</p> <p>Facility number: 000500 Provider number: 155557 AIM number: 100266220</p> <p>Survey team: Beth Walsh, RN-TC (April 23, 24, 25, 26, & May 2) Courtney Mujic, RN Karina Gates, Generalist</p> <p>Census bed type: SNF: 17 SNF/NF: 60 Total: 77</p> <p>Census payor type: Medicare: 18 Medicaid: 46 Other: 13 Total: 77</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 5/10/13 by Suzanne Williams, RN</p>	F000000		
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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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F000166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on interview and record review, the facility failed to act timely on concerns brought forth by a resident and her family member for 1 of 1 resident reviewed for grievances. (Resident #119)</p> <p>Findings include:</p> <p>An interview was conducted with Resident #119 on 4/25/13 at 11:01 a.m. regarding whether she'd ever been treated roughly by staff. She indicated, "Yes, one time they got mad and pulled my shirt over my head, and it pulled on my port site. I told (name of Admissions Director) about it. I don't know what happened. I never heard anything else about it. It was last month. No one came and talked to me about it after I told (name of Admissions Director). They were mad at me because of something my (relationship of family member) said about a paycheck."</p> <p>An interview was conducted with the Admissions Director on 4/29/13 at 2:44 p.m. regarding Resident #119's</p>	F000166	<p>F166 483.10(f)(2) GRIEVANCES</p> <p>Please accept the following plan of correction as credible allegation of compliance for the deficiency cited under tag F166, Grievances, of which all residents in the facility had the potential to be affected by. It is the policy of this facility to address grievances timely and appropriately as they are brought to the facility's attention. On 4/30/13, the ED completed a Concern Record summarizing resident #119's concerns and educated the Admissions Director about the grievance policy and procedure. Resident #119's concerns were resolved. To ensure that no other residents are affected by this deficient practice, all residents and/or their families will be interviewed by 5/24/13 in order to address any other grievances residents may have. This facility has in place a policy and procedure for responding to grievances as they are reported. The facility Administrator and Social Services Director have reviewed the corporate policy and procedure together and these procedures will be followed as written. Furthermore, all employees will be in-serviced</p>	05/24/2013	

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	<p>above statements. She indicated, "She talked to me about other concerns. Not that. She had concerns with CNA's (Certified Nursing Assistants) not putting her to bed soon enough, not answering call lights. That was when she first got here. I told social services and they followed up from there."</p> <p>During an interview with the Social Services Director (SSD) on 4/29/13 at 2:50 p.m., she indicated, "None of that sounds familiar...about the port site or (name of Admissions Director) bringing me any concerns with (name of resident #119) about the CNA's."</p> <p>During an interview with the ED (Executive Director) on 4/29/13 at 2:57 p.m., he indicated he didn't have any incidents involving Resident #119. He further indicated the Admissions Director should have filled out a report of concern about the CNA's/call lights and given it to social services, then "I'd have received a copy so it didn't fall through the cracks, like this. I will talk to (name of resident #119) and follow up with this."</p> <p>During another interview with the Admissions Director on 4/29/13 at 3:00 p.m. she indicated, "No, I did not</p>		<p>on our grievance policy and procedure on or before 5/22/13, which will also include when to put grievances into writing. To prevent recurrence: · The Social Service Director will review concerns records every morning (Monday – Friday) in department head meeting. · Grievances will be logged and addressed, accordingly · All grievances discussed will be responded to in a timely fashion, with the expectation that a practical resolution to each grievance will be found within 24 hours, but no later than 5 days. · We will continue to monitor for compliance through our QA Calling program, whereas residents and / or families are contacted monthly by QA Team department heads (Social Services, DON or designee, unit managers, DM or designee, Medical Records, and/or Administrator) regarding any questions, suggestions, or concerns that family or resident may have. Results of these calls are discussed in monthly QA meetings <i>Attachments: Grievance Policy and Procedure (1-A), Grievance Form (1-B), and Grievance Log (1-C).</i></p>		

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	<p>fill out a report of concern when (name of Resident #119 and her (relationship of family member) mentioned the CNA/call lights to me. It was more in passing. I verbally told social services. I should have filled out the report of concern. I have no documentation of (Resident #119's) concerns that were brought to me."</p> <p>The following day, on 4/30/13 at 2:40 p.m., another interview was conducted with the ED who indicated, "I went and talked to (name of Resident #119). At first, she didn't remember the port site/pulling over the shirt incident, then she did. I asked if she thought it was on purpose and she said, "I think they didn't know it was there." She couldn't remember who it was, but did remember that there was 2 of them. She also said she would tell me if she had any concerns. She also said she did tell (name of Admissions Director) about concerns with CNA's answering call lights. When I talked to (name of Admissions Director), she presented it to me as though (name of Resident #119) and her mom were discussing her preferences with her rather than concerns, but she did admit she should have filled out a concern form. I gave her a stack of concern forms and did a teachable moment with her</p>			

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	<p>on filling them out. (Name of SSD) says she does not recall (name of Admissions Director) ever telling her..."</p> <p>On 4/30/13 at 3:20 p.m., the ED provided a copy of the 4/29/13 Concern Record summarizing Resident #119's comments, the policy on grievances, and a Teachable Moment form given to the Admissions Director. The Teachable Moment form indicated, "Please follow our grievance policy and procedure. Concern forms are completed when any concern is given to a staff member. This is how we track problem solving and resolution."</p> <p>The policy indicated, "To investigate, act upon and communicate plans of action to any resident or family concern/grievance that cannot be immediately resolved...Staff will be trained upon hire and throughout employment on how to receive grievance voiced by residents and/or family members..."</p> <p>3.1-7(a)(2)</p>						

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to provide showers per the resident's choice for 1 of 3 residents reviewed for choices out of a total 5 of residents who met the criteria for choices. Resident #131.</p> <p>Findings include:</p> <p>Resident #131's clinical record was reviewed on 4/30/2013 at 1:00 pm. Diagnoses included but were not limited to; Parkinson's disease, epilepsy, hemiplegia (paralysis on one side of the body), cerebral artery occlusion with infarct (stroke).</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 4/4/2013, indicated Resident #131's BIMS (Brief Interview for Mental Status) score was 15 out of a total possible 15 points, which indicated he was cognitively aware. The Bathing section of the assessment indicated,</p>	F000242	<p>F242 483.15(b) RIGHT TO MAKE CHOICES</p> <p>It is the policy of Miller's Merry Manor for residents to have the right to choose.</p> <p>Resident #131 preferences for bath/showers frequency of shower/bath, type of shower/bath, and time/day have been added to the care plan. CNA #1 was educated on correct coding for what type of bath is completed for each resident.</p> <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents residing in the facility are not affected by this deficient practice, the facility will: Run a BIMS report of all current residents, interview residents or their families based on resident BIMS scores to determine resident preferences for showers, and care plan resident preferences for showers, and provide showers based upon residents' preferences. This will</p>	05/24/2013	

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	<p>"Bathing: How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair). Code for most dependent in self-performance and support. Bathing: self-performance: Physical help in part of bathing activity. Bathing support provided: One person physical assist."</p> <p>An interview with Resident #131, on 4/24/2013 at 10:50 am, indicated, he had not had a shower in two weeks. One of the aides usually gives him a daily wash-up, but he doesn't think that is the same as a shower. He is supposed to shower on Mondays and Thursdays.</p> <p>A care plan, dated 10/8/2012, indicated, "Focus: Preferences: Resident expresses, during the assessment process, that it is important to them to: chose what clothes to wear, take care of personal belongings, choose between shower, tub, bed, or sponge bath, have snacks available between meals, have family/friend involved in discussions re:care, to be able use phone in private. Goals: Resident will express that these needs are being met. Interventions/Tasks:...</p> <p>Determine resident's preferences for</p>		<p>be completed by 5/24/13.</p> <p>To prevent recurrence:</p> <ul style="list-style-type: none"> · All nursing staff will be in-services on or before 5/22/13 regarding correct coding for bathing and residents rights with a special emphasis on the right to choose to ensure staff delivers care per preference and per individual's plan of care · Social Services will interview all new admissions for shower preference to ensure plan of care is developed incorporating resident preference and choice · Social services staff will conduct resident / family interviews for a sample of 10 residents weekly X4 weeks, monthly X4 months, and quarterly thereafter. <p><i>Attachments: Resident's Rights Policy and Procedure (2-A), Resident Interview Section B Choices(2-B), and Family Interview Section B Choices (2-C).</i></p>				

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	<p>bathing..."</p> <p>A care plan, dated 11/23/2012, indicated, "Focus: limited to extensive assist with ADL's due to: weakness, cva, hemiplegia (at times resident c/o pain to bilateral arms and bilateral shoulders with no one touching him.) Goals: Will have needs met/anticipated as evident by clean, well groomed appearance. Interventions: Encourage to participate in ADL's as much as possible."</p> <p>An interview with CNA #1 on 4/30/2013 at 1:20 pm, indicated, "(Resident #131) is not always willing to take showers, sometimes he says he doesn't want to." Recently he's said his medication he takes makes him feel "shaky, queasy, so he'll miss it, and then later he will bring it up sometimes that he hasn't had one." She usually gets him washed up daily, in the morning, if he hasn't had a shower. Every time he misses his shower day she'll tell the nurse. She tries to tell him, okay, its your shower day and try to encourage him to take advantage of that time for a shower.</p> <p>An interview with the D.O.N. on 4/30/2013 at 1:50 pm indicated the CNA's might need to be inserviced on</p>				

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	<p>how to document a resident had a full body sponge bath, because they should be providing this when a full shower isn't possible, instead, the "AM/PM care (includes oral care)" response is documented, but most likely the resident actually got a bed bath. She will provide education on this. A resident was told on admission what their scheduled shower days will be, and at that time they can verbally agree or let nursing staff know that they would like a different shower time. The residents' shower days are scheduled according to what hallway they live on. Resident #131 has recently been feeling sleepy due to a change in his medication, so this could be why he missed some showers. The D.O.N. would be willing to alter someone's shower schedule if necessary. She also indicated, she did so for another resident.</p> <p>A document titled, "Follow Up Question Report", dated 4/1/2013 through 4/30/2013, indicated, "Question: Bath/Shower received". The following dates and times indicated, "Response: Shower (includes nail and oral care)" 4/18/2013 at 9:50, 4/29/2013 at 14:09."</p> <p>3.1-3(u)(3)</p>						

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview and record review, the facility failed to provide a resident with a wheelchair, as needed, for 1 of 1 resident reviewed for assistive devices. (Resident #154)</p> <p>Findings include:</p> <p>The clinical record for Resident #154 was reviewed on 5/1/13 at 1:15 p.m. It indicated Resident #154 was receiving hospice services.</p> <p>The 4/20/13 hospice Nurse Reassessment Visit indicated, "He does want a wheel chair so he could possibly get out of bed and go outside."</p> <p>During an interview with Resident #154 on 5/1/13 at 1:30 p.m. regarding whether he received a wheel chair, he indicated, "Now, I don't know if I can get one. I have to use someone else's. I would still like one. Hospice brought me this bed and stuff. I was</p>	F000246	<p>F246 483.15(e)(1) ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>It is the practice of Miller's Merry Manor for residents to have the right to choose and to have reasonable accommodation of needs / preferences according to Residents Rights.</p> <p>Resident #154 was provided with a wheelchair on 5/2/13.</p> <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents residing in the facility are not affected by this deficient practice, the DON conducted a wheelchair audit for all residents on 5/17/13 using the Quality Assessment Nursing Accommodations to ensure that residents whose individual needs and/or preferences were met for assistive devices such as a wheelchair.</p> <p>To prevent recurrence:</p> <p>Residents will receive a</p>	05/24/2013			

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	<p>under the impression that when they brought the bed, they were going to bring a wheelchair, but that didn't happen. I'd like to go outside if it's nice, or maybe go sit and eat in the dining room or anything, but I can't until they find someone else's wheelchair."</p> <p>During an interview with RN #3 and the DON (Director of Nursing) on 5/1/13 at 2:51 p.m. regarding a wheel chair for Resident #154, the DON indicated, "We can get a wheel chair specifically for him." RN #3 indicated, "I don't know why that hasn't been done yet."</p> <p>During another interview with the DON on 5/1/13 at 3:08 p.m., she indicated, "Normally, all residents get a wheel chair on admit if needed. I don't know how that got missed."</p> <p>During an interview with the Admissions Director on 5/1/13 at 3:30 p.m., she indicated she spoke with the therapy department who indicated Resident #154 had a wheelchair on admission when they assessed him.</p> <p>The DON was informed of the Admission Director's comment about therapy on 5/1/13 at 3:31 p.m. and she stated, "... Maybe it went to get</p>		<p>wheelchair upon admission unless contraindicated</p> <ul style="list-style-type: none"> · All nursing staff will be in-services on or before 5/22/13 regarding residents' rights with a special emphasis on the right for preferences in regards to the accommodating residents' preferences · DON or designee will conduct an audit of 10 sample residents weekly X4 weeks, then monthly thereafter using the Quality Assessment Nursing Accommodations tool to ensure that individual preferences are met for assistive devices such as wheelchairs. <p><i>Attachments: Quality Assessment Nursing Accommodations Review (3-A).</i></p>				

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	<p>cleaned and it never came back."</p> <p>The following day on 5/2/13 at 11:00 a.m., the DON was interviewed regarding whether the facility ever figured out what happened with Resident #154's wheel chair. She stated, "I don't know how long it was gone or what happened to it."</p> <p>During an interview with Resident #154 on 5/2/13 at 11:09 a.m., he pointed to the wheelchair in front of his bed, just provided by the facility, and indicated, "This is my first wheel chair since I've been here...When I got to this facility all I had was my clothes on my back...I went straight from the stretcher into the bed."</p> <p>3.1-3(v)(1)</p>				

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F000278 SS=A	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to correctly code the MDS (Minimum Data Set) assessment for 1 of 36 residents reviewed for assessments. (Resident #60)</p> <p>Findings include:</p>	F000278	F278 483.20(g)-(j) ASSESSMENT ACCURACY It is the policy of Miller's Merry Manor to accurately assess residents on an ongoing basis. Resident #60 MDS dated 12/5/2012 was coded as continent of bladder in section H0300. On 11/28/2012 bladder assessment indicated he was	05/30/2013	

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	<p>The clinical record for Resident #60 was reviewed on 4/26/13 at 11:00 a.m. The diagnoses for Resident #60 included, but were not limited to: hypertension, anxiety, and depression.</p> <p>A review of a nursing Bowel and Bladder Assessment, dated 11/28/12, indicated Resident #60 was always incontinent.</p> <p>A review of the Admission MDS assessment, dated 12/5/12, indicated Resident #60 was always continent of bladder.</p> <p>During an interview with the MDS Coordinator on 5/2/13, at 10:35, she indicated she uses the assessments done by nursing to code the MDS for bowel and bladder continence. She also indicated the Admission MDS was coded incorrectly.</p> <p>At 11:00 a.m., on 5/2/13, the DoN (Director of Nursing) indicated the MDS coordinator just fixed the MDS coding error for the Admission MDS for Resident #60.</p> <p>3.1-31(d)</p>		<p>always incontinent of bladder. Section V0200/Care area 06 was marked indicating care area was triggered and also noted as being addressed in the care plan. The care plan does correctly reflect bladder assessment of being incontinent. The CAA area also reflected that there was incontinence of bladder. To ensure that other residents in this facility were not affected by this deficient practice, the MDS Coordinator and MDS Assistant / Case Manager completed a review of 100% of the MDS's completed in the past 60 days for accuracy on section H0300. This review occurred on 5/30/13. No other MDS was found to have errors. No other residents were affected. To prevent recurrence:</p> <ul style="list-style-type: none"> The MDS and MDS assistant were in-serviced on section H0300 on 5/20/13 regarding coding of urinary incontinence. The DON or designee will complete the QA tool titled "MDS Bowel and Bladder Review" for a sample of 10 residents weekly x4, monthly x3, quarterly. This will be discontinued after 2 consecutive quarterly reviews reflect no coding errors on section H0300. <i>Attachments: H0300: Urinary Continence (4-A); Quality Assessment MDS Bowel and Bladder Review (4-B).</i> 		

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop care plans related to the diagnoses of diabetes mellitus and anxiety for 2 of 36 residents reviewed for care plans. (Resident #67 and #176)</p> <p>Findings included:</p> <p>1. The clinical record for Resident #67 was reviewed on 4/26/13 at 11:30 a.m. The diagnoses for Resident #67 included, but were not limited to: diabetes mellitus and depression. Resident #67's</p>	F000279	<p>F279 483.20 (d), 483.20 (k)(1) COMPREHENSIVE CARE PLANS</p> <p>It is the policy of Miller's Merry Manor that each resident has a comprehensive care plan to meet their medical, nursing, mental and psychosocial needs.</p> <p>On 5/2/13, resident #67 and resident #176 care plans were updated to include all diagnosis. Resident #67 no longer resides in the facility.</p> <p>All residents are at risk to be</p>	05/24/2013			

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	<p>admission date was 3/13/13.</p> <p>A review of the 3/20/13 MDS (Minimum Data Set) indicated Resident #67 had a diagnosis of diabetes mellitus.</p> <p>A Physician's Telephone Order, dated 3/3/13, indicated blood glucose finger sticks were to be done 4 times daily at 6:30 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m. No 12:00 p.m., blood sugar checks were to be done Tuesday, Thursday, and Saturday due to the Resident being at dialysis.</p> <p>A review of the April Physician's Orders indicated an order for 8 units of Lantus 100/ml (insulin) to be given daily at 9:00 a.m. for diabetes mellitus.</p> <p>During a review of the clinical record, a care plan for the diagnosis of diabetes mellitus or risk for hyper/hypoglycemia was not located in the clinical record.</p> <p>The care plans for Resident #67 included, but were not limited to: at risk for further complications due to diagnosis of CHF (congestive heart failure) and hypertension, developed on 3/15/13, renal insufficiency, developed 3/15/13, code status, and</p>		<p>affected by this deficient practice. To ensure that other residents are not affected: the DON or designee will audit all current resident care plans by 5/24/13.</p> <p>This facility has in place a policy and procedure for Nursing Care Plan Development & Review.</p> <p>To prevent recurrence:</p> <ul style="list-style-type: none"> · The DON or designee will utilize the Quality Assessment Care Plan review to audit 10 resident care plans weekly for the next month, then monthly X3 months, then quarterly · All nursing staff will be in-services on or before 5/22/13 on Nursing Care Plan Development & Review policy & procedure. <p><i>Attachments: Nursing Policy and Procedure for Care Plan Development & Review (5-A), Quality Assessment Care Plan Review (5-B)</i></p>				

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	<p>edema from multiple chronic cardiovascular disease and non-compliance with interventions, developed 4/19/13.</p> <p>During an interview with the DoN (Director of Nursing), on 5/2/13 at 10:25 a.m., she indicated staff look at a resident's diagnoses during admission and will develop a care plan related to the resident's diagnoses usually within 5 days. The DoN also indicated if a resident had a diagnosis of diabetes or anxiety/use of anti-anxiety medication, there should be a care plan developed related to the diagnosis.</p> <p>On 5/2/13, at 11:00 a.m., the DoN indicated there was a care plan that was initiated for hyper/hypoglycemia on the resident's day of admission, but it appears the care plan was never completed and she was unsure why. The DoN also indicated the care plan was just completed and was current.</p> <p>2. The clinical record for Resident #176 was reviewed on 4/26/13 at 10:30 a.m. The diagnoses for Resident #176 included, but were not limited to: depression and anxiety. Resident #176's admission date was 4/4/13.</p>						

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	<p>A review of the April Admission Physician's Orders, no specific date, indicated an order for lorazepam (anti-anxiety medication) 0.5 mg (milligrams) every 8 hours as needed for anxiety.</p> <p>During a review of the clinical record, a care plan for the diagnosis of anxiety or for the use of anti-anxiety medication was not located in the clinical record.</p> <p>The care plans for Resident #176 included, but were not limited to: edema due to multiple chronic cardiovascular disease, developed on 4/5/13, anticoagulant therapy, developed on 4/5/13, hypothyroidism, developed on 4/5/13, code status, developed on 4/4/13, and chronic sinusitis, developed on 4/5/13.</p> <p>During an interview with the DoN (Director of Nursing), on 5/2/13 at 10:25 a.m., she indicated staff look at a resident's diagnoses during admission and will develop a care plan related to the resident's diagnoses usually within 5 days. The DoN also indicated if a resident had a diagnosis of diabetes or anxiety/anti-anxiety medication use, there should have been a care plan</p>						

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	<p>developed She also indicated Social Services usually developed care plans related to anxiety and the use anti-anxiety medications.</p> <p>On 5/2/13, at 10:53 a.m., the Social Services Director indicated she usually developed anxiety/anti-anxiety medication use care plans within the first couple of days after admission.</p> <p>At 11:00 a.m., on 5/2/13, the DoN indicated a care plan for the use of anti-anxiety medication was "resolved" by Social Services and that typically means the order for the anti-anxiety medication was discontinued. The DoN indicated the anti-anxiety medication order was not discontinued for Resident #176 and she was unsure why Social Services resolved the care plan, but Social Services was looking into it.</p> <p>During an interview with the Social Services Director, on 5/2/13 at 11:15 a.m., she indicated she was unsure why the care plan was resolved when the anti-anxiety medication was not discontinued, but her best guess was that she accidentally resolved the care plan on the wrong resident. She also indicated she just fixed the care plan to make the care plan current for Resident #176.</p>						

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow an activity care plan and pain care plan for 2 of 36 residents reviewed for following care plans. (Resident #120 and #86)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #120 was reviewed on 4/29/13 at 9:45 a.m.</p> <p>The 10/23/13 Admission MDS (minimum data set) assessment for Resident #120 indicated it was very important to have books, magazines, and newspapers to read. It was somewhat important to have music to listen to and to keep up with news.</p> <p>The 11/5/12 activity care plan for Resident #120 indicated interventions were, "Resident expresses reading is important to them. Resident enjoys magazines. Activities will provide resident with magazines of choice ie. women's magazines. Resident states listening to music is important to</p>	F000282	<p>F282 483.20 (k)(3)(ii) SERVICES PROVIDED PER CARE PLAN It is the policy of Miller's Merry Manor that each resident has a comprehensive care plan to meet their medical, nursing, mental and psychosocial needs. On 5/1/13, the Activities Director (AD), provided resident #120 with a radio and magazines. On 5/10/13, maintenance hooked up resident #120's television for her to be able to watch the news. On 4/26/13, nursing contacted the physician for resident #86, and received an order to continue pain medications PRN, with no change ordered from physician. Resident #86 has discharged. All residents are at risk to be affected by this deficient practice. To ensure that other residents are not affected: the AD and the DON or designee will audit all current resident care plans by 5/24/13 and update as needed. This facility has in place a policy and procedure for Activity/ Interdisciplinary Care Plan and Nursing Care Plan Development & Review. To prevent recurrence: · The Administrator and the AD will review the Activity Care Plan Policy and Procedure</p>	05/24/2013	

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	<p>them. Resident enjoys country & most other kinds. Resident states it is important for them to keep up with news."</p> <p>During an observation on 4/29/13 at 10:42 a.m., Resident #120 was asleep in her room, snoring loudly. No magazines were observed in her room for reading. No radio was observed in her room for listening to country music. No television was observed in her room for keeping up with news.</p> <p>Resident #120's roommate was present and stated, "We need to get her a t.v. Maybe she won't sleep all day. It's not good for her. I've been here since last Thursday and she's been sleeping this whole time. I haven't seen her in any activities. I've never seen her with any magazines. She gets up for meals and then goes right back to bed. I've never seen staff encourage her to do anything. I was in here at 10:00 a.m. when the activity announcement came on and noone came in here and invited her."</p> <p>Another observation was made on 4/30/13 at 11:14 a.m. in Resident #120's room. Resident #120 was awake and watching the news on the television her roommate's son</p>		<ul style="list-style-type: none"> · All nursing staff will be in-serviced on 5/22/13, on care plan development and review · The DON or designee will utilize the Quality Assessment Care Plan Review to audit 10 resident care plans weekly for the next month, then monthly X3 months, then quarterly · The AD will utilize the Quality Assessment Activity Program Review to audit 10 resident care plans weekly for the next month, then monthly X3 months, then quarterly · The AD and DON or designee will review care plans during care plan conferences and revise, as needed <p><i>Attachments: Activity / Interdisciplinary Care Plan Policy & Procedure (6-A), Nursing Policy and Procedure for Care Plan Development & Review (6-B), Quality Assessment Care Plan Review (6-C) Quality Assessment Activity Program Review (6-D).</i></p>		

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	<p>brought in. A second television was observed on the floor in front of Resident #120's bed, not hooked up. Resident #120's roommate indicated, "She's up more now that the t.v. is here." Resident #120 stated, "I like the news and politics. I like to read. I have no magazines. I don't have a radio, but I do like country music. I'm in my room a lot."</p> <p>An interview was conducted with the AD (Activity Director) on 4/30/13 at 11:54 a.m. regarding activities available for Resident #120 to do in her room. She indicated, "I've offered her a radio. She says no." Whether she'd ever thought about just getting Resident #120 a radio and seeing if she accepts it rather than rely on her verbal answer of "no" since she's cognitively impaired, the AD stated, "No, but I see what you're saying. I should have done that. I'm still learning. We offer materials on the activity cart. I've seen her take crosswords. I've never seen her take a magazine." Regarding getting Resident #120's television hooked up, the AD indicated she was unaware she received one, but would get maintenance to hook it up.</p> <p>On 5/1/13 at 3:28 p.m. another</p>			

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	<p>interview was conducted with the AD. She indicated she took Resident #120 a radio and again, Resident #120 declined it. She indicated she told Resident #120 she would just leave it there for her in case she changed her mind. The AD indicated before she left the room, Resident #120 was asking her how to turn it on.</p> <p>2. The clinical record for Resident #86 was reviewed on 4/26/13 at 10:00 a.m.</p> <p>The April, 2013 MAR (medication administration record) indicated Resident #86 was given prn (as needed) percocet (pain medication) every single day of the month, except for 3 days.</p> <p>During an interview with RN #3 on 4/26/13 at 12:15 p.m., regarding whether Resident #86's physician was notified of her consistent daily use of the pain medication, she indicated, "No, we haven't notified the doctor. I would usually notify before now, since she's used it so much."</p> <p>The 1/16/13 pain care plan for Resident #86 indicated, "Notify MD as needed."</p> <p>3.1-35(g)(2)</p>						

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to assess a hospice resident's anxiety in accordance with his plan of care for 1 of 1 resident reviewed for hospice. (Resident #154)</p> <p>Findings include:</p> <p>The clinical record for Resident #154 was reviewed on 5/1/13 at 1:15 p.m. It indicated Resident #154 was admitted to the facility on 4/1/13 and went on hospice effective 4/23/13.</p> <p>The 4/23/13 hospice care plan for Resident #154 indicated the goal was, "Resident will have dignity and quality of life while under facility and hospice care." Interventions were, "Medications and medical supplies are provided by hospice. Facility staff will contact hospice for needed items. Medications will continue to be given per orders by facility staff. Staff nurses will contact hospice with information that affects resident care."</p>	F000309	<p>F309 483.25 PROVIDE CARE FOR HIGHEST WELL BEING It is the policy of Miller's Merry Manor that each resident has a comprehensive care plan to meet their medical, nursing, mental and psychosocial needs. On 5/2/13 Resident #154 had anxiety related to several concerns for which he had his anti-anxiety medication increased.</p> <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents at this facility are not affected by this deficient practice, the Social Services Director completed a review of 100% of resident's care plans, identifying those residents with a diagnosis of anxiety. For those residents with a diagnosis of anxiety, the SSD and Administrator (MSW) completed the anxiety review, monitoring for s/s of anxiety as noted by the Mayo Clinic. This was completed on 5/31/13, with no other residents displaying s/s of anxiety without following the interventions identified in their care plan.</p> <p>Nursing staff will be in-serviced</p>	05/31/2013			

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	<p>During an interview with Resident #154 on 5/1/13 at 1:30 p.m., he indicated he was having some financial issues he'd like to take care of and that he was agitated with it. He indicated he wasn't getting enough breathing treatments and it caused him to be in pain. He stated, "It changed from pain meds (medications) every 2 hours to every 4 hours just today. I want my every 2 hours prn (as needed) morphine scheduled. I just don't want to be in a whole lot of pain." He indicated he had to use someone else's wheelchair anytime he had to go somewhere. He stated, "Once in a while I need a shower. I haven't had a real shower since I've been here. Occasionally I'd like a shower. I haven't had my hair washed since I've been here." At this time, Resident #154 appeared anxious and agitated.</p> <p>An interview was conducted with the DON (Director of Nursing) on 5/1/13 at 3:08 p.m. regarding follow up to the above conversation with Resident #154. The DON indicated, "We are going to add albuterol every 4 hours so it falls between the duoneb (breathing treatment) schedule...The hospice nurse said when she saw him today, he had no complaints of pain,</p>		<p>on policy and procedure for Nursing Care Plan Development & Review and Anxiety by Mayo Clinic on or before 5/22/2013. To prevent recurrence: · DON or designee will conduct resident/family interviews for a sample of 10 residents weekly x4 weeks, monthly x 3 months, and quarterly thereafter during that time monitoring for s/s of anxiety as noted by Mayo Clinic. · During the interview process the DON or designee or be monitored during the interview for appropriateness of assessing for s/s of anxiety by Administrator or designee <i>Attachments: Anxiety – Information provided by Mayo Clinic (7-A); Quality Assessment Anxiety Review (7-B).</i></p>		

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	<p>so we are going to leave the pain med schedule alone for now..."</p> <p>During an interview with the DON on 5/2/13 at 11:00 a.m., she commented, "He was really anxious yesterday."</p> <p>During another interview with Resident #154 the following day on 5/2/13 at 12:10 p.m., he stated, "I just want a breathing treatment when I need it. If it's at an hour and a half, I want to be able to get it." Resident #154 appeared anxious and agitated.</p> <p>During a third interview with Resident #154 on 5/2/13 at 11:09 a.m., he indicated, "They came in and talked to me. I'm agitated with my billing. The Business Office Manager did come talk to me. This is my first wheelchair since I've been here. (Resident #154 pointed at the wheelchair in his room). I had a shower yesterday...my first one..." Again, Resident #154 mentioned his breathing treatments not being sufficient. Again, Resident #154 appeared anxious and agitated.</p> <p>On 5/2/13 at 12:09 p.m., a telephone interview with the nurse at the pulmonary clinic at which Resident #154 had a consultation on 4/30/13</p>						

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	<p>was conducted. She indicated, "The doctor didn't change anything. We didn't send any paperwork back with him. There is a visit note, 'Reschedule to clinic as needed. No changes at this time. No known drug allergies.' He saw (name of doctor at pulmonary clinic)."</p> <p>During an interview with the DON (Director of Nursing) on 5/2/13 at 12:20 p.m. regarding all of Resident #154's comments about his breathing treatments, pain medications, etc., she stated, "Okay, I will tell hospice."</p> <p>During another interview with the DON on 5/2/13 at 1:00 p.m., she indicated she spoke with hospice who seemed to think it was an anxiety issue. She indicated his anxiety medication would be changed.</p> <p>The 5/2/13, 12:30 p.m. Physician's Telephone Order indicated an increase in his anxiety medication to, "Klonopin 1 mg po (by mouth) 3x 1 day @ 6 a, 2 pm & 10 pm -Anxiety. Klonopin 1 mg po every 4 hours PRN Anxiety."</p> <p>3.1-37(a)</p>						

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to ensure a resident's personal hygiene and cleanliness was maintained for 1 of 3 residents reviewed for activities of daily living, out of a 3 of residents who met the criteria for activities of daily living. Resident #101.</p> <p>Findings include:</p> <p>Resident #101's clinical record was reviewed on 4/26/2013 at 1:28 pm. Diagnoses included, but were not limited to; depressive disorder, diabetes, dementia.</p> <p>An interview with CNA #2 on 4/29/2013 at 2 pm indicated, Resident #101 was a one person assist, and he was legally blind.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 2/28/2013, indicated Resident #131's BIMS (Brief Interview for Mental Status) score was 7 out of a total possible 15 points, which indicated he was</p>	F000312	<p>F312 483.25 (a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>It is the practice of Miller's Merry Manor that each resident shall be bathed or assisted to bathed as frequently as is necessary, but at least twice weekly, per: ISDH Nurse Aide Manual..</p> <p>Resident #101 is on the weekly shower list for 2 times a week. Social service interviewed resident #101's family on 5/17/13 regarding bathing preferences and added to plan of care for preference of showers.</p> <p>All residents are at risk to be affected by this deficient practice. To ensure that other residents residing in the facility are not affected by this deficient practice, the facility will: Run a BIMS report of all current residents, interview residents or their families based on resident BIMS scores to determine resident preferences for showers, and care plan resident preferences for showers, and provide showers based upon residents' preferences. This will</p>	05/24/2013			

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	<p>cognitively limited. The Bathing section of the assessment indicated, "Bathing: How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair). Code for most dependent in self-performance and support. Bathing: self-performance: Physical help in part of bathing activity. Bathing support provided: One person physical assist."</p> <p>A care plan, dated 11/23/2012, indicated, "Focus: Needs supervision to extensive assist with ADL's due to: vision impairment, weakness. Goals: Will have needs met/anticipated as evident by clean, well groomed appearance. Interventions: Encourage to participate in ADL's as much as possible. Keep physician and family updated with current ADL status thru care plan meetings."</p> <p>An interview with a family member, on 4/25/2013 at 11:19 am, indicated, the following question was asked, "does [resident's name] receive the same number of baths or showers in a week based on past preferences?" The family member indicated, "no". Also, his "clothes are dirty" when she comes to visit three times a week. The family member indicated she</p>		<p>be completed by 5/24/13.</p> <p>This facility has in place a policy and procedure for ADL assistance</p> <p>To prevent recurrence:</p> <ul style="list-style-type: none"> · All nursing staff will be in-services on or before 5/22/13 regarding policy & procedures for bathing and offering alternatives if/when residents decline, and adequately charting bathing · Social Services will interview all new admissions for shower preference to ensure plan of care is developed incorporating resident preference and choice · Social services staff will conduct resident / family interviews for a sample of 10 residents weekly X4 weeks, monthly X3 months, and quarterly thereafter. · DON or designee will audit showers daily for all residents for 30 days, will audit a sample of 10 residents weekly X 4 weeks, then will audit a sample of 10 residents monthly X3 months <p><i>Attachments: Nurse Aide Training: Bathing Policy & Procedure (8-A), Resident Interview (8-B), Family Interview (8-C), Quality Assessment Tool</i></p>				

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	<p>"assumes they (the facility) aren't showering him enough, but isn't sure."</p> <p>An interview with CNA #2, on 4/29/13 at 2 p.m., indicated, Resident #101 was an evening shower person. CNA #2 also indicated she wasn't sure whether or not Resident #101 actually gets them/ever resists showers because she doesn't work the evening shift. She cleans him up daily, as needed. CNA #2 indicated she, "washes his face, and his bottom after he goes to the bathroom."</p> <p>A document titled, "Follow Up Question Report", dated 3/1/2013 through 4/27/2013, indicated, "Question: Bath/Shower received." The following dates and times indicated, "Response: Shower (includes nail and oral care)" 3/9/2013 at 22:59, 3/23/2013 at 20:31, 3/27/2013 at 21:20, 3/30/2013 at 19:55, 4/3/2013 at 22:59, 4/10/2013 at 19:42, 4/13/2013 at 19:53, 4/17/2013 at 20:59, 4/27/2013 at 5:11.</p> <p>3.1-38(a)(3)</p>		Shower Audit (8--D)		

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident at risk for malnutrition was provided interventions in accordance with her plan of care for 1 of 3 residents reviewed of 8 who met the criteria for nutrition. (Resident #102)</p> <p>Findings include:</p> <p>The clinical record for Resident #102 was reviewed on 4/25/13 at 10:00 a.m. It indicated Resident #102 had a BMI (body mass index) of 16.5.</p> <p>According to www.cdc.gov, a BMI of below 18.5 for a female indicated a weight status of underweight and a normal BMI for a female was indicated as 18.5 to 24.9.</p> <p>During an interview with LPN #4 on 4/24/13 at 11:34 a.m., she indicated</p>	F000325	<p>F325 483.25(i) MAINTAIN NUTRITIONAL STATUS</p> <p>It is the policy of this Miller's Merry Manor to maintain acceptable parameters of nutritional status and for residents to receive a therapeutic diet when there is a nutritional problem..</p> <p>On 4/29/13, resident #180 (not actually resident #102) was provided with a house shake at the end of her meal. On 4/30/13, the Dietary Manager met with resident #180 (not actually resident #102), reviewed her food preferences in regards to supplements, and changed her house supplement to a Magic Cup. On 5/7/13, the DM again reviewed resident's food preference for supplements and changes her to ensure, per resident's food preferences. The DM also reviewed resident's preferences for HS snacks and began providing HS snacks</p>	05/24/2013	

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	<p>Resident #102 was receiving house shakes with each meal as a nutritional supplement, but could not provide any documentation to verify this.</p> <p>The 4/12/13 nutrition care plan for Resident #102 indicated the goal was for her to consume 51% or more of meals. Interventions were to provide her with a house shake with each meal, a bedtime snack, to monitor weights and intakes, and snacks available to her between meals upon request.</p> <p>The 4/16/13 nutritional assessment for Resident #102 indicated, "Recommend offer 4 oz. house shake with all meals d/t (due to) low Alb (albumin), low BMI."</p> <p>The 4/17/13 Physician's Telephone Order indicated, "Offer a house shake (4 oz) (symbol for "with") each meal-dietary to provide."</p> <p>An observation of Resident #102's lunch meal in the main dining room was made on 4/29/13 at 12:11 p.m. Her tray was delivered with a slice of meatloaf, a piece of cake, a bowl of ice cream, a bowl of carrots, potatoes, and a side salad. No house shake was provided with her</p>		<p>according to resident's preference (5/17/13).</p> <p>All residents are at risk to be affected by this deficient practice. To ensure that other resident residing in the facility are not affected by this deficient practice, the DM will conduct an interview with all resident who are using a supplement to determine preferences and will update resident care plans with supplement of their preference unless contraindicated (QA Tool – Dietary Services Review – Supplement Preferences).</p> <p>This facility has in place a policy and procedure for maintaining nutritional status, including a Supplementation Decision Making Tree which encompasses resident meal consumption percentages and a policy and procedure for HS snacks.</p> <p>To prevent recurrence:</p> <ul style="list-style-type: none"> · The Administrator and DM reviewed the Policy and Procedure for Weight Loss and for HS snacks on 5/15/13 · All staff will be in-serviced on or before 5/22/13, on accurate documentation for meal consumption, and the HS snacks policy and procedures · The DM will utilize the Dietary Services Review – 		

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	<p>meal. By the end of her meal, Resident #102 consumed a couple of bites of carrots, a couple of bites of potatoes, most of her side salad, no meatloaf, no cake, no ice cream, and still had not received her house shake.</p> <p>An interview was conducted with LPN #4, the Unit Manager on Resident #102's unit, on 4/29/13 at 1:13 p.m. in the dining room at Resident #102's table. LPN #4 provided a copy of Resident #102's lunch meal ticket at this time. The ticket indicated Resident #102 was to receive a house supplement of 4 oz. and that more than 51% of her meal was consumed. The remainder of Resident #102's food was still on the table. LPN #4 indicated she did not see any remnants of a house shake, nor did it look like Resident #102 ate over 51% of her meal as her meal ticket indicated.</p> <p>During another interview with LPN #4 on 4/29/13 at 1:35 p.m. she stated, "I don't have any method to ensure nurses are documenting these tickets accurately. (Name of LPN #5) filled out the ticket. I told the Dietary Manager and they are going to see if she wants something else to eat and offer her her shake."</p>		<p>Supplement Preferences to audit supplements daily (M-F) for 4 weeks, weekly for 3 months, and monthly thereafter</p> <ul style="list-style-type: none"> · The DM will provide a list of all dietary supplements provided with meals and the DM or designee will monitor in the dining room for accuracy each meal (M-F) for 30 days. · The DM will complete the QA Tool – Dietary Services Review – and will audit 100% of HS Snacks daily for 4 weeks, weekly for 3 months, and monthly thereafter · The DON or designee will complete the QA Tool – Dietary Services Review – Meal Consumption daily for 4 weeks, weekly for 3 months, and monthly thereafter · We will also continue to monitor for compliance through our monthly QA process, where we will review the Dietary Services Review tool monthly until resolved . <p><i>Attachments: Dietary Policy and Procedure for weight loss (9-A), Dietary Policy and Procedure for Bedtime snack policy (9-B), QA Tool Dietary Services Review Supplement Preference(9-C,), QA Tool Dietary Services Review HS Snacks (9-D), and Dietary Services Review Meal</i></p>				

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	<p>An interview was conducted with Resident #102 on 4/30/13 at 11:21 a.m. She indicated she did not receive evening snacks like her care plan indicated and stated, "I wouldn't mind a late night snack." Regarding whether she asked for snacks between meals as care planned, she stated, "They've never said anything. I didn't know I could ask. They never told me." Regarding house shakes at mealtimes, she stated, "Sometimes they give them to me. Sometimes they don't. They're nasty. I try to drink them, but it's hard. I'd like for them to try something else, because they're not good."</p> <p>3.1-46(a)(1)</p>		Consumption (9-E)		

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F000368 SS=E	<p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>Based on observation, interview, and record review, the facility failed to offer a bedtime snack to all residents. This affected 3 residents and had the potential to affect 36 other residents who do not receive 9:00 p.m. medications (Residents #171, 86, 117).</p> <p>Findings include:</p> <p>During an interview with Resident #86, at 2:15 p.m. on 4/24/13, Resident #86 indicated the facility provided lunch at 12:00 p.m. and dinner at 5:00 p.m. Resident #86 also indicated, after 5:00, they (the</p>	F000368	<p>F368 483.35(f) SNACKS AT BEDTIME</p> <p>It is the policy of this Miller's Merry Manor to offer a bedtime snack to all residents.</p> <p>On 4/30/13, a key to the kitchen was provided to evening shift nursing staff. Resident #86 and #171 have discharged from the facility.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>This facility has in place a policy and procedure for HS snacks.</p>	05/24/2013

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(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>residents) don't eat again until 8 a.m. or 9 a.m., the next morning. Resident #86 indicated, "They don't pass evening snack. In the 4 months I've been here, I've asked for a snack around 7:30ish and they've told me the kitchen is locked."</p> <p>On 4/24/13 at 2:54 p.m., Resident #171 indicated the facility needed to provide snacks after dinner because he was usually hungry again in the evening, because dinner was not usually as big as lunch.</p> <p>During a random observation on 4/25/13 at 9:03 p.m., there was a container of cookies on the South Nurse's Station and the doors to the kitchen were locked.</p> <p>During an interview with Resident #171, on 4/25/13 at 9:05 p.m., Resident #171 indicated he did not receive a snack that evening and he was hungry.</p> <p>LPN #11 indicated on 4/25/13, at 9:05 p.m., cookies were passed during medication pass. LPN #11 was unsure if the kitchen was locked or where the keys were, if the kitchen was locked. LPN #11 also indicated, the South pantry contained some resident's own personal snacks, but</p>		<p>To prevent recurrence:</p> <ul style="list-style-type: none"> · The Administrator and DM reviewed the Policy and Procedure for HS snacks · The Social Services Director reviewed the practice of providing HS snacks with Resident's Council on 5/16/13. · The DM or designee will utilize the Dietary Services Review HS snacks to audit HS snacks are being provided. This tool will be utilized for 100% of residents daily for 4 weeks, weekly for 3 months, and monthly thereafter · All staff will be in-serviced on HS snacks on or before 5/22/13 · We will continue to monitor for compliance through our monthly QA process, where we will review the Dietary Services Review tool monthly until resolved. <p><i>Attachments: Dietary Policy and Procedure for Bedtime snack policy(10-A), and Dietary Services Review – HS Snacks (10-B).</i></p>				

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	<p>he was unsure if any other facility snacks were available for residents to have.</p> <p>At 9:09 p.m., on 4/25/13, Resident #117 indicated he had not received a snack and he was hungry.</p> <p>During an interview with CNA #10, on 4/25/13 at 9:10 p.m., she indicated the nurses pass cookies to residents with their medications, in the evening.</p> <p>Resident #77 indicated on 4/25/13 at 9:12 p.m., she was hungry and hadn't received her snack, but she wanted a peanut butter and jelly sandwich, but she knew that she would only get a cookie when she asked.</p> <p>On 4/25/13, at 9:15 p.m., CNA #9 indicated the kitchen was closed/locked and she wouldn't be able to get a peanut butter and jelly sandwich for Resident #77, but the nurses pass cookies to residents with their evening medications. She also indicated the facility used provide sandwiches as a bedtime snack, but there haven't been sandwiches for awhile.</p> <p>A policy titled, Bedtime Snack Policy, dated 11/27/12, was provided by the DoN (Director of Nursing) on 5/1/13 at</p>						

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	<p>1:24 p.m.. It indicated, "It is the policy of (Name of Facility) to offer a bedtime snack to all residents."</p> <p>A review of a list, no title, provided by the Administrator, on 5/2/13 at 12:15 p.m., indicated which residents received 9:00 p.m. medications. Resident #171, #86, #117 were not on the list. 38 residents were listed as residents who received medication at 9:00 p.m. and the facility census was 77.</p> <p>3.1-21(e)</p>			

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F000371 SS=F	<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 store and prepare foods under sanitary conditions. This had the potential to affect 72 residents in the facility who ate food from the kitchen of a facility census of 77.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted with the FSM (Food Services Manager) on 4/22/13 at 12:00 p.m.</p> <p>Upon observation of the reach-in refrigerator, a jar of ranch dressing, a jar of french dressing, a bottle of mustard, a bottle of salsa, and a bottle of relish were observed each with its' respective condiment on the outside of the container, near the lid, on the lid, around the lid, and progressively down the sides of the container. A can of chocolate syrup was observed with a green, furry mold substance growing at the top of the can next to the syrup that was on the</p>	F000371	<p>F371 483.35(i) FOOD SANITATION</p> <p>It is the policy of this Miller's Merry Manor that all foods shall be stored and protected under safe and sanitary conditions.</p> <p>On 4/22/13, the Dietary Manager (DM), disposed of all products in the reach-in refrigerator that had product on the outside of the container. The DM also cleaned the beef base container and the sprinklers on 4/22/13.</p> <p>All residents are at risk to be affected by this deficient practice.</p> <p>This facility has in place a policy and procedure for Food Protection and Storage, as well as a Dieatary Food Safety Sanitation Checklist.</p> <p>To prevent recurrence:</p> <ul style="list-style-type: none"> The Administrator and DM reviewed the Policy and Procedure for Food Protection and Storage on 5/17/13 	05/24/2013			

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	<p>outside of the can. The FSM threw the can of chocolate syrup away and stated, "This should not be in here." A red sauce was observed on the inside walls of this refrigerator. A container of jelly was observed inside, undated. The FSM stated, "The refrigerator is deep cleaned weekly. Everything is wiped down...containers and the refrigerator itself. Daily, we check for discards, dates and anything that needs wiped down."</p> <p>Upon observation of the dry storage area, a 400 oz. beef base container was observed with product on the lid. The FSM stated, "It's the product. It needs wiped down."</p> <p>The stove hood was observed with 4 black, cylindrical sprinklers with excess dust covering them as well as the overhead lights. The sprinklers were located directly above the stove. The FSM stated, "We clean the filters every month. The Kitchen Exhaust Hood Cleaning Company comes every 6 months and cleans the rest. They were here in February. We could wipe the sprinklers down ourselves."</p> <p>The Dietary Manual for the kitchen was provided by the DON (Director of Nursing) on 5/1/13 at 1:24 p.m. It</p>		<ul style="list-style-type: none"> · The Dietary Manager will utilize the Dietary Food Safety Sanitation Checklist to audit for sanitation. This tool will be utilized daily for 4 weeks, weekly for 3 months, and monthly thereafter · All dietary staff will be in-serviced on or before 5/22/13, on Food Safety Sanitation · We will continue to monitor for compliance through our monthly QA process, where we will review the Dietary Food Safety Checklist tool monthly until resolved . <p><i>Attachments: Dietary Policy and Procedure for Food Protection and Storage (11-A), Dietary Food Safety Sanitation Checklist (11-B).</i></p>		

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	<p>indicated, "CLEANING HOOD FILTER AND HOOD OVER STOVE A. MONTHLY: VII. To clean interior and exterior of hood, use detergent diluted with water according to directions. Rinse thoroughly with clean warm water...CLEANING REFRIGERATOR A. WEEKLY: B. REACH-IN TYPE III. Check with supervisor, and sort out and throw away all food that is not usable. IV. Remember, leftovers should (sic) be dated and used up within three (3) days..."</p> <p>3.1-21(i)(3)</p>				