

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/21/2014
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 0548 S 100 W HARTFORD CITY, IN 47348
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F000000	<p>This visit was for the Investigation of Complaint IN00144596.</p> <p>Complaint IN00144596 - Substantiated. Federal/state deficiency related to allegation is cited at F309.</p> <p>Survey date: February 21, 2014</p> <p>Facility number: 000289 Provider number: 155576 AIM number: 100289460</p> <p>Survey team: Shelley Reed, RN</p> <p>Census bed type: SNF: 3 SNF/NF: 48 Total: 51</p> <p>Census payor type: Medicare: 7 Medicaid: 37 Other: 7 Total: 51</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</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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F000309 SS=D	<p>Quality review completed by Debora Barth, RN.</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.</p> <p>Based on record review and interview, the facility failed to identify significant decline in bladder output for greater than 48 hours and obtain the appropriate services to prevent prolonged urinary output decline for 1 of 3 residents reviewed for urinary incontinence. (Resident B)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident (B) was reviewed on 2/21/14 at 9:30 a.m. Diagnoses for Resident (B) included, but were not limited to, dementia, dysphagia, hypertension and chronic kidney disease.</p> <p>The Quarterly Minimum Data Set</p>	F000309	F309 Provide Care/Services for highest Well Being: It is the policy of Miller's Merry Manor, Hartford City to 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. Resident B had no adverse effects as a result of this deficient practice. The nursing staff had identified resident issue of decreased urine output. The facility contacted the hospice company overseeing the resident's care. The resident did have a foley catheter anchored. Resident was receiving hospice services. Had notable decline from 2/2/14-2/4/14. Resident expired 2/4/14. Resident showed no s/s pain or discomfort during this time frame. All residents have	03/21/2014	

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	<p>(MDS) assessment, dated 12/7/14, indicated Resident (B) was severely cognitively impaired. Resident (B) received the following Activities of Daily Living (ADL) assistance; transfer-limited assistance with two person physical assist, ambulation-did not occur, dressing-total dependence with one person physical assist, hygiene and bathing-total dependence with one person physical assist. Resident (B) was frequently incontinent of bowel and always incontinent of urine.</p> <p>A health care plan problem, dated 2/4/14, indicated Resident (B) had a potential problem for exacerbation of chronic renal failure. One of the goals for this problem indicated the resident would have no signs or symptoms of complications related to renal insufficiency. Interventions for this problem included monitoring nutritional intake and weights and monitoring lab reports as ordered. Another health care plan problem indicated Resident (B) had persistent positive urine cultures without specific symptoms. Interventions for this problem included to monitor for changes in bowel/bladder patterns and monitor fluid intake-offer extra water between meals to increase free flow</p>		<p>the potential to be affected by this deficient practice. All residents with foley catheters have been reviewed along with plan of care to ensure appropriate documentation for urine output is present. No other issues were identified. Policies and Procedures have been reviewed regarding charting procedures. See attachment A. A mandatory in-service will be conducted on March 21, 2014 for all nursing staff. Charting Procedures will be addressed, so that all nursing staff is aware that all documentation should be complete, concise, and factual. Staff should chart only what they are able to hear, see, smell, and touch not what they think or what they have been told by other staff members. We will also be reviewing decline in bladder function and appropriate services to prevent prolonged urinary output decline. See attachment B. During the mandatory in-service all nurses will be educated on adding the catheter output task in the computer. DON or her designee will monitor all documentation related to urinary output for accuracy weekly x 1 month, bi-monthly x 1 month, and monthly thereafter x 4 until determined resolved by the QA committee. See attachment C. Any issues noted will be logged on the QA Summary Log and reviewed and followed through the facility monthly QA meeting.</p>		

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	<p>water hydration.</p> <p>The nursing notes, dated 2/2/14 at 1:40 p.m., indicated the resident did not have urine output "this shift". The note indicated LPN #2 called Resident (B)'s hospice company related to no urine output for 48 hours.</p> <p>During an interview on 2/21/14 at 2:09 p.m., LPN #2 indicated she documented no urine output for 48 hours because she was informed that was the case during staff to staff reporting.</p> <p>Another nursing note by LPN #1, dated 2/3/14 at 3:30 p.m., indicated no urine output for 40 hours.</p> <p>During an interview on 2/21/14 at 2:20 p.m., LPN #1 indicated she documented no urine output for 40 hours. She indicated Resident (B) did have decreased urine output.</p> <p>A nursing note, dated 2/2/14 at 9:36 p.m., indicated Resident (B) had received an indwelling catheter placed by a hospice nurse.</p> <p>A nursing note, dated 2/4/14 at 8:55 a.m., indicated a correction to an earlier nursing note. The correction</p>		<p>Overview of Mandatory In-service- see attachment D. Systemic changes will be completed by March 21, 2014. IDR Request for F309 The facility respectfully requests a paper review for the deficiency cited in the complaint survey conducted 2-21-14. The citation was related to "the facility failed to identify significant decline in bladder output for greater than 48 hours and obtain appropriate services to prevent prolonged urinary output decline". Resident B was receiving hospice services for end of life care. Resident B was admitted to hospice care 1-31-14. She continued to show decline and active signs of dying from 2/2-2/4/14 on which day she did expire. LPN #2 documented on 2/2/14 "the resident did not have urine output this shift". It was also noted "hospice company notified related to no urine output for 48 hours". LPN #1 documented the next day (2/3/14) at 3:30pm "Cath clarification: Insert cath d/t no urine output for 48 hours". This charting was not accurate and subsequently was struck out by LPN #1. The resident had the foley catheter placed 2/2/14 at which time there was noted urine output. There is also an entry dated 2/3/14 at 7:56 am which does describes the urine output. There is also a note written 2/4/14 at 4:01 am which states "urine output &lt;25cc". Further assessment per nurses note</p>		

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	<p>indicated Resident (B) had no urine output for 8 hours. The correction was made by the Assistant Director of Nursing (ADoN).</p> <p>During an interview on 2/21/14 at 2:50 p.m., the ADoN indicated she reviewed the weekend documentation and changed the nursing note because she assumed it was a typo error. She indicated she did not talk to any nursing staff that cared for Resident (B) except the CNA who worked the night shift. She indicated the CNA stated Resident (B) did have urinary output but could not account for the additional 40 hours of decreased urine output. She indicated a resident should go no longer than 8 hours without urinating. She indicated staff were then to call the physician for orders.</p> <p>During an interview with the Director of Nursing (DoN) on 2/21/14 at 3:45 p.m., additional information was requested related to the urine output monitoring. She indicated the staff did not initiate that task in the computer and Resident (B) went 2 days without urine output monitoring. She indicated any resident with a catheter was monitored for urinary output.</p>		<p>2/4/14 at 10:01 am states "no urine output this shift". At this time resident continued to have decline and did expire at 10:51am. After review of Resident B's ADL legend (toileting tasks) for the above dates, we have come to the conclusion that resident received extensive assist with toileting on all shifts in question. Staff members did not document "8,8" which would indicate the task did not occur. We have reviewed Resident B's BM report in which two of the five shifts resident did have a BM, it appears as though resident did void the remaining three shifts since "8,8" (did not occur) was not charted. Please see attachment. In conclusion, after further review, resident had went approximately eight hours without voiding. Staff had appropriately assessed and contacted hospice services. A foley catheter was anchored. The resident at no time showed signs of distress related to urine output. The facility feels the staff did assess her needs and appropriate interventions were provided in a timely manner.</p>				

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	<p>During an interview with the ADoN on 2/21/14 at 3:45 p.m., additional information was requested related to the anchored catheter insertion assessment dated 2/2/14 at 5:12 p.m. The assessment was initiated by the ADoN, indicating a 14 French catheter was placed and 220 mL of urine was obtained. The assessment indicated Resident (B) tolerated the procedure well. The ADoN indicated she back-dated the assessment to reflect when the catheter was placed. She indicated she obtained the above information from the nurse who was caring for Resident (B). She indicated she did not catheterize the resident and was not in the building during that time.</p> <p>A facility policy, dated 2/1/13, titled "Catheter Use," provided by the DoN on 2/21/14 at 4:05 p.m., included, but was not limited to, the following:</p> <p>"...2. Procedure: Complete the catheter assessment located in the EMR [electronic medical record] for all residents prior to placement of a urethral catheter..."</p> <p>IV. Need to measure exact amount of urinary output for short period (14 days or less."</p>			
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	This Federal tag related to Complaint IN00144596.  3.1-37(a)			