

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2016
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 7, 8, 11, 12, 13, & 14, 2016</p> <p>Facility Number: 000163 Provider Number: 155262 AIM Number: 100291380</p> <p>Census bed type: SNF: 6 SNF/NF: 49 Total: 55</p> <p>Census payor type: Medicare: 11 Medicaid: 32 Other: 12 Total: 55</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 04/14/2016 by 29479.</p>	F 0000		
F 0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL			

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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Bldg. 00	<p>PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure pressure ulcer interventions to prevent a cognitively impaired resident, admitted without a pressure ulcer, but identified at risk for development of pressure ulcers, from developing a stage 3 (full thickness tissue loss) pressure ulcer on the right medial, plantar area (sole) of the foot. (Resident #13).</p> <p>Finding includes:</p> <p>On 4/11/16 from 1:15 p.m., Resident #13 was observed sitting in her room in her wheelchair. The resident was sitting in a position with her right foot resting on top of her left foot. A pillow was observed between the resident's knees and the foot buddy (device that provides slotted areas for the feet when in a wheelchair), was on the footrest of the wheelchair.</p> <p>On 4/12/16 at 10:26 a.m., during an</p>	F 0314	<p>F 314 Treatment/Services to Prevent/Heal Pressure Sores</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F 314.</p> <p>1. It is the policy of Miller's Merry Manor to assess for and reduce risk factors that may contribute to the development of pressure ulcers. This includes risk assessment, care plan implementation, skin care, nutrition, repositioning, support surfaces, communication, documentation, education, and quality assurance review.</p> <p>2. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) Staff education was initiated on 4/18/16 with licensed nursing staff and nurse aides on Preventing Pressure Ulcers. (Attachment A, pages 1-6) Completion date for education 4/30/16. 2) All current residents identified at risk for skin breakdown were audited to</p>	04/30/2016	

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	<p>observation of the wound treatment to the resident's right foot, a pressure ulcer measured 1 cm (centimeter) x 0.5 cm x 0.3 cm.</p> <p>On 4/11/16 at 1:28 p.m., during an interview, RN #1 indicated the resident had a stage 3 pressure area to her right medial plantar area. She indicated it was determined that the wound was due to the resident sitting with her right foot on top of her left foot.</p> <p>On 4/11/16 at 2:57 p.m., RN #4 indicated the staff placed the resident's feet into the foot buddy when she was in her wheelchair. She indicated the resident as the resident changed position she ended up positioned with one foot on top of the other.</p> <p>On 4/13/16 at 2:19 p.m., RN #1 indicated the resident was identified at risk for pressure ulcers on the care plan dated 6/15/09. She indicated interventions were placed for pressure prevention that included turning and repositioning every 2 hours, weekly skin assessments by a nurse and pressure reducing devices to her chair and bed. She indicated interventions were added to the care plan after the wound was discovered that included, but were not limited to, floating the heels when in bed, initiation on a</p>		<p>ensure appropriate interventions are in place. Completion date 4/27/16. 3) When the specific source of pressure is identified for a resident, this will be included on the Nurse Aide Assignment Sheet. This has been completed for all current residents with a completion date of 4/27/16. 4) All new admits identified at risk for skin breakdown will have appropriate interventions put in place to minimize the risk. These interventions will be placed on the care plan and nurse aide assignment sheets as appropriate.</p> <p>3. The corrective action will be monitored to ensure the deficient practice will not recur by the Director of Nursing or designee through the attached QA Tool (Attachment B). Monitoring will occur daily for one week, weekly for 4 weeks, then monthly thereafter for 6 months. Any issues will be corrected immediately, recorded on the facility QA Tracking Log and reviewed in the facility QA meeting monthly with any new recommendations implemented.</p> <p>4. Corrective actions completed by 4/30/16.</p> <p>IDR Request for Survey Event ID PO7711 for F 314 Miller's Merry Manor of Sullivan is requesting a paper review IDR of F-314. Through this process we request that the tag be deleted completely. As stated in the 2567 report, page 2, the facility was</p>				

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	<p>leg/foot buddy, pillows between the resident's legs to prevent skin-to-skin contact, increased protein with meals and an oral supplement. The RN indicated the resident had not been observed to sit in the position of one foot on top of the other prior to the discovery of the pressure area on 2/2/16. The RN indicated the CNA's (certified nursing assistant) assessed the resident's skin each time they provided care and would report any changes to the nurse. She also indicated the nurse performed a weekly skin assessment and would report any findings of changes to the resident's skin. She indicated no concerns were reported prior to the discovery of the area on 2/2/16.</p> <p>On 4/14/16 at 9:10 a.m., CNA #2 indicated the CNA's were aware of the wound on the resident's right foot. She indicated she had not been informed of how the resident developed the wound. She indicated she made sure the resident had a pillow between her legs to prevent skin-to-skin contact when the resident was in her wheelchair and made sure her feet were placed into the foot buddy. She indicated when the resident was in bed, her heels were floated and a pillow was placed between her legs to prevent skin-to-skin contact, and she checked, turned and repositioned the resident every</p>		<p>found to be out of compliance due to failing to ensure pressure ulcer interventions were in place for a resident that developed a pressure ulcer. Page 5 of the 2567 indicated that the care plan did not specify interventions of foot buddy or floating heels when in bed. The facility feels unjustly cited for Resident #13 since preventative interventions were in place prior to development of a pressure ulcer and said interventions were in fact included on the care plan. Please see the following attachments to support this:</p> <ul style="list-style-type: none"> ·Attachment C, pages 1-2; potential for skin risk care plan, that indicates an intervention of 'float heels while in bed' that was initiated on 8/12/2015 along with many other interventions in place prior to 2/2/16. ·Attachment D, CNA assignment sheet that was in use at time of survey and the exact copy given to the surveyors while in the building which shows resident is a pressure risk and interventions in place listed under Misc. Information. ·Attachment E, Assistive device care plan for use of leg buddy aka foot buddy. This care plan was initiated 2/12/15 and had been in place and effective for one year. The leg buddy care plan is new information that was not requested by the survey team. Upon exit, the survey team was unable to give any specifics to the 				

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	<p>2 hours. The CNA indicated the resident's skin was assessed each time care was provided and she would report any change of the resident's skin to the nurse. She indicated she had never observed the resident sitting in a position where her foot was resting on top of the other foot.</p> <p>On 4/14/16 at 9:30 a.m., CNA #3 indicated all staff were aware of the wound on the resident's foot. She indicated she had not been informed of how the resident developed the wound. The CNA indicated she had witnessed the resident sitting with one foot on top of the other foot and assisted the resident's feet into the foot buddy. She indicated she always made sure the resident's legs had a pillow between them and her feet are placed into the foot buddy when she was up in her wheelchair. She said when the resident was in bed she floated her heels and placed a pillow between her legs. She indicated the resident was checked every 2 hours when she was in bed and was turned and repositioned.</p> <p>On 4/11/16 at 12:58 p.m., review of Resident #13's medical record, indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease unspecified and other chronic pain.</p> <p>Review of a document titled, "New Skin</p>		<p>tag other than related to pressure ulcer concern leaving it impossible for the facility to discuss the concern during exit or provide any additional information. In conclusion, we feel that there was an appropriate plan of care in place with interventions in place for pressure ulcer prevention and that F-314 should be deleted. Thank you for your time and consideration in reviewing this request.</p>				

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	<p>Alteration Assessment," dated 2/2/16, indicated a 3 cm x 2 cm black dry hard scab was noted to the resident's right medial plantar area. No depth measurement was indicated.</p> <p>A document titled, "Wound-Pressure Ulcer Assessment with Braden" dated 2/2/16, indicated the resident had a new in-house acquired unstageable pressure ulcer to her right medial plantar area. The document indicated the wound measured 3 cm x 2 cm with no depth measure indicated.</p> <p>A document titled, "Wound-Pressure Ulcer Assessment with Braden," dated 4/12/16, described the wound as a healing stage 3 pressure ulcer to the resident's right medial plantar area. The document indicated the wound measured 1 cm x 0.5 cm x 0.3 cm.</p> <p>Review of the resident's quarterly MDS (minimum data set) assessment, dated 5/5/15, indicated the resident had severe cognitive deficit. The assessment indicated the resident was extensive assistance with 2-plus person physical assist with bed mobility, and was at risk for the development of pressure ulcers.</p> <p>Review of a significant change MDS assessment, dated 2/2/16, indicated the</p>			

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	<p>resident was at risk for pressure ulcers and had an unstageable area that was covered by eschar or slough.</p> <p>A care plan, titled, "Potential for skin breakdown" was initialed 6/25/2009. Interventions included, but were not limited to, assist with turning and repositioning (revised 7/28/2009), float heels while in bed (initiated 8/12/2015), head to toe skin assessment (revised 5/19/2010), low air loss mattress (initiated 02/02/2016), pressure reducing device to chair (revised 7/28/2009), and positioning devices to prevent skin on skin contact (initiated 02/02/2016). The care plan did not specify interventions of the foot buddy or floating the resident's heels when in bed.</p> <p>A current policy document titled, "Skin Management Program," dated 8/14/14, indicated, "1. PURPOSE: A. It is our policy to assess for and reduce risk factors that may contribute to the development of pressure ulcers ...2. PROCEDURE: I. A comprehensive head to toe assessment (inspection) will be completed by a licensed nurse upon admission/return, and at least weekly thereafter...E. REPOSITIONING FOR THE PREVENTION OF PRESSURE ULCERS: I. Repositioning should be done to reduce the duration and</p>			

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	<p>magnitude of pressure over vulnerable areas of the body...G. COMMUNICATION: L...Nursing staff will communicate changes via the 24 hour condition report and written or electronic nurse aide assignments...."</p> <p>3.1-40(a)(1)</p>				