

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| F0000 | <p>This visit was for the Investigation of Complaint IN00098083.</p> <p>Complaint IN00098083-Substantiated, Federal/State deficiency related to the allegations is cited at F-309.</p> <p>Survey dates: 10/17/11 and 10/18/11</p> <p>Facility number: 000286 Provider number: 155579 AIM number: 100291000</p> <p>Survey team: Sharon Whiteman, RN</p> <p>Census bed type: SNF/NF: 67 Total: 67</p> <p>Census payor type: Medicare: 07 Medicaid: 43 Other: 17 Total: 67</p> <p>Sample: 03</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 | |
| F0309 SS=G | <p>Quality review completed on October 24, 2011 by Bev Faulkner, RN</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 thoroughly assess, monitor, treat, and seek new treatment orders for a skin rash, which led to the resident yelling out in pain when incontinence care was provided and led to rash area worsening for 1 of 2 residents reviewed for wounds in a sample of 3. (Resident A)</p> <p>Findings Include:</p> <p>During initial observation tour on 10/17/11 at 11:40 a.m., with LPN (Unit Manager) #1 present, Resident A was identified by LPN #1 as being confused, not reliable for interview, required 1 staff for assistance, was propelled in a wheelchair by staff, had cellulitis on her legs and a rash on her bottom which was being treated with Dermafungal ointment.</p> <p>On 10/17/11 at 1:00 p.m., Resident A was observed seated in her recliner. The</p> | F0309 | <p>An IDR has been submitted for this citation. F309-Provide care for highest well being Each resident in this facility will receive the necessary care and services to attain or maintain the highest practicable physical. mental, and psychosocial well being. The facility submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F309. Resident A remains a resident of this facility. Resident A was the only resident cited during survey. The Incontinence Associated Dermatitis is now healed.. Nystatin powder order to groin and buttocks continues prn. On 10/24/2011 the orders for duoderm to right buttock and Dermafungal were discontinued due to healing. A new order for protective ointment to buttocks and perigenital area as needed received. Resident A has a wheelchair pressure-relieving cushion in place. Resident receives Acetaminophen 650mg BID for pain and Ultram 50mg</p> | 11/09/2011 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>resident's family was present in the room and indicated the resident had just been transferred from her wheelchair to her recliner. The resident's wheelchair was observed to not have any type of cushion in the seat of the chair.</p> <p>On 10/17/11 at 3:45 p.m., CNA #1 and CNA#2 were observed to transfer the resident from the resident's wheelchair to a bathroom commode. The resident was observed to not have any type of cushion in her wheelchair. The CNA's were observed to remove a wet brief. The brief appeared to be heavy with urine and had a dark yellow/tan discoloration in the groin area of the brief. While the CNA's performed incontinence care, the resident yelled out, "OW that hurts." The resident's entire groin area appeared to be dark purple in color. Her inner buttocks was reddened with a rash and two pinpoint open dark red areas. CNA #2 indicated "You (Resident A) are really red down there." The CNA's indicated they didn't normally work on the hall Resident A resided on. CNA #1 indicated she remembered the resident had a "little bit" of redness when she returned from the hospital, but that it had been awhile since she had taken care of Resident A. CNA #2 indicated she was going to look for some creme. The CNA returned with a tube of "Sensicare Creme" (barrier creme)</p> | | <p>every 4 hours as needed for moderate pain. When asked to rate pain, Resident A indicates 0 or 1 to question. All current frequently incontinent residents have the potential to be affected by this deficient practice. All frequently incontinent residents were assessed and no additional Incontinence Associated Dermatitis was identified. To prevent reoccurrence, nursing staff will receive in-service training under the direction of the Director of Nursing/Designee. This in-service will include review of the following policies: Skin Management Program Care Plan Development and Review Comprehensive Assessment and Charting Procedure All residents will be assessed on admission, daily or weekly assessments, quarterly, significant change and prm. Any resident that are identified with Incontinence Associated Dermatitis will be treated per physician order. Pain will be assessed and managed. Physician orders will be present on MAR and TAR and progress will be regularly monitored per facility documentation policy. The corrective actions will be monitored by use of Assessment QA tool, titled Skin Management Review for Incontinence Associated Dermatitis (Attachment A). After first identification of Incontinence</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (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>and applied the creme to the resident's bottom and groin area. The resident yelled out in pain when this creme was applied. There was no "Dermafungal Creme" in the resident's drawer.</p> <p>Interview of CNA #1 on 10/17/11 at 4:52 p.m., indicated she was told that Resident A had diarrhea "a few days ago." CNA #1 indicated when Resident A was incontinent "We wash her and put the Sensicare on her." We don't necessarily tell the nurse every time she's (Resident A) incontinent but we tell the nurse when the area is worse . We told the nurse about the pin point areas.</p> <p>Interview of RN #1 on 10/17/11 at 5:00 p.m., indicated she had just done a treatment on Resident A's bottom. RN #1 indicated she had applied a Duoderm dressing to the new open area on the resident's bottom. RN #1 indicated she did not look at the resident's groin area. RN#1 indicated Resident A received a treatment just once a shift for her bottom and anytime anybody puts something on the resident's bottom after she is incontinent was fine. RN #1 indicated the Sensicare was a good barrier creme and it was fine for the CNA's to use this creme on the resident's bottom. RN #1 was observed to transfer Resident A from her recliner to her wheelchair. No cushion</p> | | <p>Associated Dermatitis or other New Skin Alteration Assessment (non-occurrence) an audit will be done daily for 7 days, weekly for 4 weeks, and on a monthly basis thereafter. The frequency will be reevaluated by the Quality Assurance Team with continuance as deemed appropriate. All Systemic changes and in servicing will be completed by Nov. 9, 2011. ATTACHED ARE THE SIGNED COVER PAGE AND 1 ATTACHMENT and the IDR follows: November 4, 2011 Re: Millers Merry Manor – Hope, IDR request to Survey Complaint(Number (IN00098083) Susie Scott, Informal Dispute ResolutionIndiana State Department of HealthLong Term Care Division.2 North Meridian StreetIndianapolis, IN 46204 To Whom it May Concern: Millers Merry Manor-Hope is requesting a face to face IDR of the following F Tag:F309- Provide Care/Service for Highest Well Being, with a scope and severity of G. We are asking that this tag be deleted from the survey, or that at minimum the G tag be reduced in Scope and Severity F309Please consider the following summary of items we are disputing. More details related to this dispute can be found in the attachments. In the documentation below, you will see our argument. This outlines</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>was observed in the resident's wheelchair.</p> <p>During daily exit conference with the Administrator and the DON [Director of Nursing] on 10/17/11 at 5:30 p.m., the DON indicated she thought Resident A had a cushion for her wheelchair. Documentation of skin area descriptions was requested from the DON at this time.</p> <p>Interview of RN #2 (Charge Nurse on hall Resident A resided on) on 10/18/11 at 9:00 a.m., indicated she had not checked the resident's skin yet, but the CNA's did. RN #2 indicated she did not look at the resident's inner groin area yesterday.</p> <p>Interview of LPN #2 (MDS nurse) on 10/18/11 at 9:07 a.m., indicated the facility did not have a wound nurse, but each resident was given a head to toe assessment weekly, which was done by the charge nurse. LPN #2 indicated after the red galled area was reported yesterday, she and LPN #1 (Unit Manager) "went in & assessed (Resident A's) skin and wrote up assessment and received new order." LPN #2 indicated when the resident was admitted from the hospital she had a rash with "closed satellite pustules." LPN #2 indicated the resident had received a lot of antibiotics in the hospital. LPN #2 indicated she had not looked at the resident's inner thigh yet.</p> | | <p>we do not agree with several points used in an attempt to show that we failed to assess, monitor , treat, and seek new treatment orders for a skin rash. This facility did provide pain management to resident. Resident A was admitted to the hospital on 10/1/11 and returned to facility on 10/5/11. During her hospital stay she received intravenous antibiotics including Cipro and Zosyn as well as Avelox, Zithromax, and Rocephin. Other meds Resident A received while in hospital were SoluMedrol and Prednisone. The resident was continued on Avelox and Prednisone after re-admission to facility for a period of 5 days. The resident was also diagnosed with Stage 3 Chronic Kidney disease with a baseline creatinine of 1.4 and a GFR of 39 per her hospital admission history and physical. Due to her impaired kidney function, clearance time for the multiple medications is slower. The progress of her candidal incontinence associated dermatitis was slowed due to the continued Avelox and Prednisone administration which were completed on 10/10/11. Until the predisposing factors were eliminated, healing would not thoroughly progress. The resident was assessed on admission and determined to have an incontinence associated rash as well as the hospital diagnosed</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>On 10/18/11 at 9:35 a.m., with the DON, RN #2 and LPN #2 present, Resident A was transferred from her bedside chair to her bed for observation of her skin. The resident's inner buttocks was observed to be reddened with dark red area around the edges. The resident's labia and groin area were observed to be reddened. The resident yelled out in pain when Dermafungal (an anti-fungal ointment for wound treatment) was applied.</p> <p>Interview of LPN #2 on 10/18/11 at 11:45 a.m., indicated staff were using both the Nystatin (anitfungal powder) and the Dermafungal. LPN #2 indicated treatment was being done daily and staff were monitoring, but do not document unless something is new or there is a change or if a treatment was not working. LPN #2 indicated she thought CNA's were calling the whole area "buttocks." LPN #2 indicated the resident's MDS and care plan were due to be updated "today."</p> <p>Interview of LPN #1 (Unit Manager) on 10/18/11 at 12:10 p.m., indicated Resident A's doctor was not notified of the resident's reddened labia and inner thighs because it was not a change. LPN #1 indicated CNA's monitor residents skin during showers and mark on the shower sheets if there is a change in the residents</p> | | <p>candidal interigo. The readmitting orders from the hospital included Nystatin powder to groin and left breast 4 X daily. After skin assessment, the Unit Manager called the physician to advise of rash and an additional order for Dermafungal every shift and after incontinent episodes was received. The resident was assessed for pain on admission and rated pain as 0. On the second day after readmission (10/6/11), the resident rated her pain as 1 indicating that it hurt a little bit. Resident was already receiving Tylenol 325mg tabs 2 PO 2x daily. The Unit Manager obtained a breakthrough pain analgesic, Ultram 50mg one tab PO prn every four hours. An order was also received for Acidopholis tabs 2 PO twice daily in an attempt to enhance the development of normal flora in turn reducing the candidal infection. The nurses did document on 10/6, 10/11, 10/13,, and 10/14 that the treatment continues but did not admittedly describe the appearance per policy nor frequency of assessment. On 10/16/11, it was discovered that 2 "pinpoint" (0.1x0.1) open dark areas on inner buttocks were present. The physician and family were notified and a new order for Duoderm dressing change every 3 days until healed received. The Physician Nurse Practitioner saw resident and another new order</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (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>skin.</p> <p>Copies of Resident A's shower sheets were provided by LPN #1 on 10/17/11. A shower sheet, dated 10/06/11, indicated Resident A had a "rash" on her buttocks. A shower sheet, dated 10/08/11, indicated Resident A's buttocks were "a little red." A shower sheet, dated 10/10/11, indicated Resident A had a "rash" on her buttocks. A shower sheet, dated 10/13/11, indicated Resident A had a "rash" on her buttocks. A shower sheet, dated 10/15/11, indicated Resident A had no skin issues, breakdown, or redness. This shower sheet was signed by LPN #1.</p> <p>Interview of RN #2 (Charge Nurse on floor Resident A resided) on 10/18/11 at 12:30 p.m., indicated she was not aware the resident had a reddened inner peri area and inner thighs until this morning. RN #2 indicated she would have had the CNA's put the Dermafungal on after the resident was incontinent had she known when the resident was incontinent. RN #2 indicated the Dermafungal was in kept in stock at the facility.</p> <p>Review of Resident A's clinical record on 10/17/11 at 12:00 p.m., indicated the resident had diagnoses which included, but were not limited to, Alzheimer disease, cellulitis, and congestive heart</p> | | <p>was received for Diflucan100mg tabs 2 po daily for 4 days. On page 2 of the 2567, the surveyor noted that a wheel chair cushion was not in place. Resident A did indeed have a wheel chair cushion but the cushion was removed for washing due to her frequent incontinence per wheelchair cleaning schedule. Cushion was aired thoroughly and returned to resident later the same day. On page 3 of the 2567, the surveyor described the wet brief as "heavy with urine and had a dark yellow/tan discoloration in the groin area of brief". Patients in Chronic Kidney Disease Stage 3 may have urination changes. Per Davita.com, urination changes may be foamy if there is protein it, or dark orange, tea colored or red if there is blood in it. A person may urinate more or less, or get up to the bathroom at night". See Attachment A. The yellow/tan appearance on brief was residue of the Nystatin treatment which is same in color. The C. N. A's should have referred to the C.N.A assignment sheet for the treatment of Dermafungal cream. The appropriate cream was replaced in room. However, they were appropriate in giving proper incontinent care. The resident did indicate pain during incontinent care and Dermafungal application, but this tactile intervention would be unavoidable. The resident did</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (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>failure.</p> <p>A "...Nursing -Transfer to hospital" form, dated 10/01/11 at 12:47 a.m., indicated, "...Resident yelled out for help to get up and walk to bathroom. This nurse assisted. Resident having increased difficulty with gait....complaints voiced of difficulty breathing and this nurse noted increase in respiratory rate...O2 [oxygen] sats [saturation] 66% room air...O2 [Oxygen] applied at 3 LPN [liters per nasal cannula] then O2 sats 76%...increased O2 to 4 LPN then O2 sats 88-90%....Lung sounds coarse throughout....complaints of feeling hot. Notified MD on call and new order received to send to ER [Emergency Room]."</p> <p>A weekly assessment form, dated 10/5/11, (day the resident returned from the hospital to the facility) indicated a section titled "New skin Alteration Findings." This section had areas to check mark for any "new wound noted" and "New rash/Excoriation." These areas were not check marked. This section also had areas for nursing to document descriptions/locations of any wounds. These areas were left blank.</p> <p>An "Admission Information, sheet, dated 10/05/11, included, but was not limited to,</p> | | <p>take ordered Tylenol and was also receiving PRN Ultram during the course of treatment. On page 10 of the 2567, an updated care plan was in progress for Resident A. Resident was readmitted to the facility on 10/05/11. Per RAI regulation, the facility has 21 days to complete a care plan after admission. Resident had only been in facility 11 days when surveyor in building and the care planning was still in process. In conclusion, the facility's position is that the resident was admitted with an incontinence associated rash with candidal interigo. More orders were obtained after admission to promote healing of this rash, but until predisposing medications such as additional antibiotic and steroid therapy were discontinued and excreted completely from body, the rash was unlikely to completely heal. Resident's physician was timely notified of condition and new orders received. It is admitted that the rash descriptions and frequency were lacking, but the resident did not suffer actual harm while being treated for this condition. The pain associated with incontinent care was unavoidable but resident did have a pain management program. Residents' rash has since healed since the clearance of steroids and antibiotics and ordered treatments. We look forward to discussing this case with you in person. We will be waiting on</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (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>a section for skin issues. This sections was check marked in a box beside the words "rash/excoriation." This section also included "List Type of alteration(s); location(s); Measurement-length, width, depth; Description: Documented in this area was, "bottom has incontinence dermatitis, resident arrived and was incontinent of bowel and bladder upon arrival." No measurements or other description was documented. The information sheet lacked documentation indicating any other reddened or rash areas other than the resident's bottom.</p> <p>A physician's order, dated 10/05/11, indicated, "Nystatin Powder (anti-fungal powder) - apply under left breast and groin QID [4 times daily]."</p> <p>A physician's telephone order, dated 10/05/11, indicated, "....Apply Dermafungal Q [every] shift &...[after] ea [each] incont [incontinent] episode."</p> <p>A physician's order, dated 10/06/11, indicated, "Acidophilus (probiotic supplement) 2 tabs po [by mouth] BID [twice daily]...for colon health...Ultram (pain medication) 50 mg [milligrams] 1 po PRN [as needed] Q 4 HR [hours] for moderate pain."</p> <p>A "...Daily Nursing-assess</p> | | <p>your response and date to do so.Thank you for consideration in this matter. Sincerely yours, Susan Carol Wilkins, HFA ONE MORE ATTACHMENT FOLLOWS IN REGARD TO CHRONIC KIDNEY DISEASE</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>[assessment].....,"dated 10/11/11, indicated Resident A had no "New Skin Alteration Findings." Check mark areas for these sections were blank. This assessment lacked documented description and measurements of the rash areas.</p> <p>A Medicare MDS [Minimum Data Set] assessment, dated 10/12/11, indicated Resident A had cognitive impairment; required extensive assistance of staff for transfers, hygiene, and bathing; was frequently incontinent of bowel and bladder. The assessment indicated Resident A was at risk for skin break down and was receiving application of ointments other than to her feet.</p> <p>A "ViewProgress [sic] Note," dated 10/16/11 at 20:40 (8:40 p.m.), was provided by the DON on 10/18/11 at 9:30 am. This note indicated, "Resident [Resident A] has been crying and yelling out for help and then has difficulty remembering what she was yelling for....Groin and buttock red from frequent incontinence. Changed frequently; Nystatin powder applied."</p> <p>A care plan (not dated) indicated, "At risk for skin breakdown D/T [due to] incontinence & Alzheimer dementia. Approaches for the care plan were</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (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>Monitor skin Q [every] shift for S/SX [signs/symptoms] of potential skin breakdown (E.G. redness/dicoloration or open areas. Alert charge nurse if observed for notification of physician as needed to obtain TX [treatment] orders...."</p> <p>A care plan, (not dated), indicated, "Resident is incontinent of urine frequently & uses incont [incontinent] briefs, is at risk for UTI [urinary tract infection]." The short term goal for this care plan was "resident will remain free of UTI." Interventions for this care plan were, "Medicate as ordered with....Monitor for S/Sx [signs/symptoms] of UTI (c/o [complaints] of pain/burning...Assist to toilet upon rising, before and after meals at bedtime on command."</p> <p>A Medication Record for October, 2011 indicated Resident A received the Dermafungal treatment daily - once a shift on 10/06/11 through 10/17/11. The Medication Record lacked documentation supporting Resident A receiving the Dermafungal treatment after incontinent episodes. The Medication Record indicated Resident A received the Nystatin Powder 4 times daily from 10/06/11 - 10/17/11.</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (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>A physician's order, dated 10/17/11, (no time documented) indicated, "Clean area to (R) [right] buttocks c [with] NS [normal saline] apply Duoderm - change every 3 days & PRN."</p> <p>A copy of a wound assessment was provided by LPN #1 on 10/18/11 at 10:40 a.m. The wound assessment, indicated, " Type of wound: Incontinence associated dermatitis...Location of wound: area is on anterior side of right buttocks." The assessment indicated the area measured 0.1 centimeters by 0.1 centimeters in length and width and the area was 0.1 centimeters in depth. The date and time of this assessment was 10/17/11 at 4:46 p.m. The assessment lacked documentation supporting whether or not the resident's groin area and perineum reddened/rash areas were assessed by nursing.</p> <p>An updated care plan was found in the front of Resident A's clinical record on 10/18/11 at 10:00 a.m. The care plan indicated, "Focus - 10/5/11 Location - bilateral buttocks with erythema (diffused redness over the skin) and closed satellite pustules scattered throughout due to incontinence while at acute hospital - 10/17/11 actual skin breakdown due to incontinence on bilateral buttocks. This care plan indicated, "Date initiated:</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (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>10/5/2011...Revision on: 10/18/11." Interventions on this care plan included, "Nurse to measure/assess weekly & notify family & physician as needed....administer topical treatment to bilateral buttocks as per MD order...Administer treatment - clean with normal saline - apply Duoderm and change every 3 days and PRN as ordered - Provide with pressure reducing device to chair." The "Goals" for this care plan were to show reduction in size of open area and show no signs of infection.</p> <p>Interview of the DON [Director of Nursing] on 10/18/11 at 12:00 p.m., indicated the Nurse Practitioner was in with Resident A to look at the rash areas. The DON indicated nursing staff toileted Resident A every 2 hours.</p> <p>A physician's telephone order, dated 10/18/11 (no time documented), indicated, "cleanse area on (R) buttocks c NS [normal saline]. Apply Duoderm, change q 3 days and PRN. Continue current treatment to peri-area, groin and rash/excoriated area q shift and PRN. Difflican (oral anti-fungal medication) 100 mg [milligrams] ii [2] tabs po [by mouth] today then i [1] po qd [every day] x [time] 4 days. This order was written by the Nurse Practitioner.</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (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>A policy titled "Wound & Non-Would Assessment & Documentation" was provided by LPN #1 on 10/17/11 at 4:00 p.m. The policy was dated 11/02/10. The policy indicated, "...Non-Wound Skin Alterations...All non-wound skin alterations, as defined below, will be managed by the licensed staff nurses. Initial assessment and documentation will be completed on the 'Nursing-New skin alteration assessment' or if on a new admit on the 'Nursing-admission/return assessment' or if due to an occurrence on the 'nursing occurrence initial assessment' or on the 'nursing daily assessment...The non-wound area will be placed on the TAR [Treatment Administration Record] with instructions to monitor at least daily until it is healed....Definition of non-wounds:Rash - skin eruption caused by allergy or irritation. Dermis [skin] is rough or bumpy and reddened. Pain or itching may be present....."</p> <p>This Federal/State Finding relates to Complaint IN00098083.</p> <p>3.1-37(a)</p> | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/09/2011

FORM APPROVED

OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/18/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 | |
| | | | | | |