

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155573	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/18/2015
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 14, 15, 16, 17, and 18, 2015</p> <p>Facility number: 000342 Provider number: 155573 AIM number: 100289140</p> <p>Census bed type: SNF: 4 SNF/NF: 28 Total: 32</p> <p>Census payor type: Medicare: 6 Medicaid: 23 Other: 3 Total: 32</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 30576 on September 24, 2015.</p>	F 0000	<p>Please accept this Plan of Correction as our credible allegation of compliance. We respectfully request consideration for Paper Compliance for these deficiencies due to the low number of deficiencies and low scope and severity.</p>	
F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the</p>			

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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	<p>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 a physician order for a anti contracture device in the right hand and failed to follow a careplan for a washcloth in bilateral hands to prevent further contractures for 1 of 2 residents who met the criteria for range of motion and failed to follow a careplan to provide fluids between meals and at the bedside for 1 of 2 residents who met the criteria for hydration of 19 residents reviewed for careplan's and physician orders (Resident #10 and Resident #43).</p> <p>Findings include:</p> <p>1.) Interview with RN #6 on 9/14/15 at 1:38 p.m., indicated Resident #10 had an contracture of the right arm and did not utilize a splint device or receive range of motion services.</p> <p>During observation on 9/14/15 at 2:11 p.m., Resident #10's bilateral hands were clenched in a fist, the resident did not have a splint device in place.</p> <p>Review of the electronic health record of Resident #10 on 9/16/15 at 12:55 p.m., indicated the resident's diagnoses</p>	F 0282	<p>F282 – Services by Qualified Persons/Per Care Plan</p> <p>The facility respectfully submits the following plan of correction as proposed remedies to the cited concerns, of which all residents have the potential to be affected.</p> <p>To correct this deficient practice, all residents with contractures will be reviewed for a program to be in place to prevent further decline in range of motion or other complications related to contractures. All residents will be reviewed to identify any residents</p>	10/16/2015

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	<p>included, but were not limited to, dementia without behavioral disturbance, dysphasia, dysfunction of bladder, diabetes mellitus type 2, mood disorder, generalized osteoarthritis, anxiety, spondylosis, malaise, constipation, hypertension and anemia.</p> <p>The occupational therapy plan of care for Resident #10, dated 6/29/15, indicated the resident held her right hand in a clenched position with fowl smell in palm and nail indentations. The resident's hand was able to open 50% before the patient complained of pain. The resident will never have functional use of hand due to severe dementia, but hand needs to be held open enough for hygiene and to prevent palm breakdown. The long term goal was the resident will tolerate a (name of anti hand contracture device) in the right hand to maintain range of motion needed for hygiene and to prevent palm breakdown.</p> <p>The Quarterly Minimum Data (MDS) assessment for Resident #10 dated, 7/7/15, indicated the resident had impairment on one side for functional limitation in range of motion.</p> <p>The physician order for Resident #10, dated 7/10/15, indicated the resident was to utilize right hand (brand name of anti</p>		<p>not able to have water available at bedside/within reach. All other residents with have fresh water passed per policy. Physician orders will be transcribed &amp; implemented per policy. Care plans &amp; Nurse Aide assignment sheets will be updated as appropriate. Therapy will communicate using the form titled "Therapy Discharge Recommendations" to nursing &amp; MDS coordinator prior to discharge in both the weekly Medicare meeting and to the floor staff for training. The MDS Coordinator will be responsible for follow up and implementation of recommendations from therapy.</p>	

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	<p>hand contracture device) at all times except/excluding hand hygiene and grooming to reduce risk for contractures.</p> <p>The careplan for Resident #10, dated 9/15/15, (revision date) indicated the resident had contractures of bilateral hands. The interventions included, but were not limited to, apply wash cloths to bilateral hands gently spreading each finger 5-10 times before applying and monitor for verbal and non verbal indicators of pain.</p> <p>During observation on 9/16/15 at 12:28 p.m., Resident #10 was sitting in a tilt and recline chair in the dining room being fed lunch by staff. The resident's hands were clinched in a fist and the resident did not have wash cloths or a anti hand contracture device in her hands.</p> <p>Interview with Resident #10's family member #1 on 9/16/15 at 10:02 a.m., indicated they had not seen a washcloth or (name of anti hand contracture device) in the resident's hands. Family member #1 indicated at one time occupational therapy was working with the resident, but was unsure if the facility provided exercise or range of motion for the resident.</p> <p>Interview with Resident #10's family</p>		<p>All Nursing staff will be in-service Oct 7, 2015 on the following policies: Restorative Nursing Program Procedure (Attachment A), Care Plan Development &amp; Review (Attachment B), Water Pass Procedure (Attachment C), New Orders – Verbal/Telephone (Attachment D) and Therapy Discharge Recommendations (Attachment E). To monitor for reoccurrence of this deficiency, the QA Tool Restorative &amp; Hydration (Attachment F) will be completed by DON or designee 5 days a week for 2 weeks, weekly for 4 weeks, then monthly thereafter. Any concerns will be addressed</p>	

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	<p>member #2 on 9/16/15 at 3:50 p.m., indicated for a period of time the facility had put washcloths in the resident's hands. Family member #2 indicated the resident had been digging her nails into the palm of her hands.</p> <p>During observation on 9/17/15 at 9:15 a.m., Resident #10 was laying in bed with her eyes open. The resident's hands were clinched in a fist position and there were no washcloths or anti hand contracture device in her hands.</p> <p>Interview with LPN #5 on 9/17/15 at 12:28 p.m., indicated the CNA's were responsible to put washcloths in Resident #10's hands. LPN #5 attempted at this time to apply washcloth's in the resident's hands and the resident resisted. LPN #5 then transferred the resident into her tilt and recline chair and attempted again to put the washcloths in the resident's hands and was successful putting a washcloth in both hands without difficulty.</p> <p>The "new orders" policy provided by LPN #9 on 9/18/15 at 11:40 a.m., indicated the purpose of the policy was to ensure physician orders were transcribed correctly and carried out per plan.</p> <p>2. During an interview, on 9/15/15 at 11:42 a.m., Resident #43 indicated he did not get fluids between meals, and he</p>		<p>immediately, recorded on a facility QA tracking log and reviewed at the monthly QA meeting with any new recommendations implemented.</p> <p>The facility will be in compliance by October 16, 2015.</p>		

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	<p>usually doesn't have a water pitcher. No water pitcher was observed in his room at that time.</p> <p>Resident #43's record was reviewed on 9/16/15 at 10:08 a.m. Physician's readmission orders dated 9/8/15 indicated Resident #43 had diagnoses that included, but were not limited to, dementia with behavior disturbance, coronary artery disease, high blood pressure, anemia, and pacemaker.</p> <p>A quarterly Minimum Data Set assessment, dated 7/17/15, indicated Resident #43 was moderately impaired in cognitive skills for daily decision making, required limited assist of one person physical assist for eating/drinking, and limited assist of one person for walking.</p> <p>A care plan, last revised on 6/15/15, indicated: Focus: "Risk for dehydration related to: dementia, chronic renal insufficiency, pudding thick liquids and meals (may have thin liquids after oral care and between meals). Goals: Show no signs of dehydration. Interventions/Tasks...encourage resident to increase po (by mouth) fluids...keep water at bedside for easy access, may have thin water, juices, and coffee between meals...no straws..."</p>			

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	<p>On 9/16/2015, at 2:48 p.m., Resident #43 was observed in his room in his recliner asleep and there was no water pitcher in his room.</p> <p>On 9/17/2015, at 9:59 a.m., Resident #43 was observed asleep in his recliner, a water pitcher was on the bed side table out of reach of the resident, and there was a straw in the water pitcher.</p> <p>On 9/18/2015, at 10:26 a.m., Resident #43 was observed in his recliner asleep and there was no water pitcher in his room.</p> <p>During an interview, on 9/18/2015 at 10:30 a.m., CNA #7 indicated she didn't know why Resident #43 didn't have a waterpitcher in his room; it had something to do with fluids, but she would have to ask his nurse.</p> <p>During an interview, on 9/18/2015 at 12:11 p.m., the Director of Nursing (DoN) indicated Resident #43 should not have a water pitcher at his bedside. He said the "no straw" on the care plan was for when Resident #43 received thickened liquids and he didn't have a speech therapy evaluation that indicated he shouldn't have a straw. The "no straw" intervention was a standard part of</p>			

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F 0309 SS=D Bldg. 00	<p>the care plan for a resident who received thickened liquids.</p> <p>A policy and procedure for "Care Plan Development &amp; Review", dated 2/24/14, was provided by the DoN on 9/18/15 at 2:50 p.m. The policy indicated, but was limited to, "1. Purpose: A. To assure that a comprehensive care plan of reach resident includes measurable objectives and timetables to meet the residents medical and psychosocial needs that are identified in the comprehensive assessment process...Care plans will be revised daily and PRN (as needed) as changes in the resident's condition dictate. Changes include but are not limited to changes in Physician orders, diet changes, therapy changes...5. Communication to staff: A. Care plans must be part of the medical record and accessible to all clinical staff. B. Nurse aides are advised of the residents care plan focuses and interventions that are within their scope of practice via assignment sheets and/or...EMR (electronic medical records)."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p>			

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	<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 accurately complete a skin assessment for a resident with bruising for 1 of 3 residents who met the criteria for skin conditions non-pressure and failed to complete a bowel and bladder assessment for a resident who had a significant change in bowel and bladder function for 1 of 1 resident who met the criteria for decline in continence status (Resident #32 and Resident #48).</p> <p>Findings included:</p> <p>1.) During observation on 9/15/15 at 10:17 a.m., Resident #32 had two purple and blue bruises on the top of her right hand.</p> <p>During observation on 9/16/15 at 12:31 p.m., Resident #32 had two purple and blue bruises on the top of her right hand.</p> <p>Review of the record of Resident #32 on 9/17/15 at 3:30 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer disease, altered</p>	F 0309	<p>F309 Provide Care/Services for Highest Well Being.</p> <p>The facility respectfully submits the following plan of correction as proposed remedies to the cited concerns, of which all residents have the potential to be affected.</p> <p>To correct this deficient practice, all residents will have a head to toe skin assessment completed with any findings addressed per policy. All residents will be reviewed to ensure supplemental</p>	10/16/2015

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	<p>mental status, dementia without behaviors, mood disorder, osteoporosis and hypothyroidism.</p> <p>The weekly nursing assessment for Resident #32 dated, 9/16/15, indicated the resident's skin was assessed and there were no findings of bruising.</p> <p>The careplan for Resident #32, dated 8/21/15, (revision date) the resident was at risk for developing skin tears and or bruising due to decreased subcutaneous tissue secondary to the aging process and other diseases. The goal was the resident would have less than 2 skin tears/bruising in one month.</p> <p>During observation on 9/17/15 at 11:48 a.m., Resident #32 had three bruises on the top of her right hand. The bruises were blue/dark blue and purple.</p> <p>During observation on 9/17/15 at 2:00 p.m., LPN #5 measured the bruising on Resident #32's right hand bruise (1) was below the thumb and measured 3.3 centimeters (cm) by 2.0 cm, bruise (2) was below the pointer finger measured 1.9 cm by 1.7 cm and bruise (3) was between middle and ring measuring 2.4 by 2.1 cm.</p> <p>The Nursing occurrence initial</p>		<p>(Combo ) assessment has been completed that correlates with the most recent MDS assessment. The Combo assessment includes: Fall risk, side rail assessment, elopement risk, bowel &amp; bladder assessment and skin risk assessment. Care plans will be reviewed and updated with any new combos that need completed.</p> <p>All nursing staff will be in-serviced Oct 7, 2015 on the following policies: Wound &amp; Non-Wound Assessment &amp; Documentation (Attachment G) and Charting Procedure giving special attention to section 4-C (Attachment H). This in-service will also include direction to all</p>	

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	<p>assessment for Resident #32 dated, 9/17/15 at 2:00 p.m., indicated the resident had three bruises on her right hand. There was a bruise below the thumb measuring 3.3 centimeters (cm) by 2.0 cm, bruise below the pointer finger measuring 1.9 cm by 1.7 cm and a bruise between the middle and ring finger measuring 2.4 cm by 2.1 cm. There was no pain associated with these areas. Current treatment was to monitor bruises for seven days.</p> <p>Interview with the Director of Nursing (DON) on 9/18/15 at 10:50 a.m., indicated there was no documentation of an assessment of Resident #32's bruising on her right hand prior to 9/17/15.</p> <p>The wound and non-wound assessment policy provided by the Administrator on 9/17/15 at 1:35 p.m., indicated all non-wound skin alterations will be managed by the licensed nurse. An initial assessment and documented. "Bruises will be monitored at least daily for 7 days for complications such as pain that may indicate need for further assessment."</p> <p>2.) Review of the electronic health record of Resident #48 on 9/16/15 at 10:11 a.m., indicated atrial fibrillation, hypertension, dementia with behaviors, hypothyroidism, kidney failure, age</p>		<p>staff to be observant during any care and to report all pertinent observations/unusual findings to nurse in charge. A review of a complete head to toe skin assessment will be provided to all Nurses. To monitor for reoccurrence of this deficiency, the QA tool Skin &amp; Charting (Attachment I) will be completed by DON or designee 5 days a week for 2 weeks, weekly for 4 weeks, then monthly thereafter. Any concerns will be addressed immediately, recorded on a facility QA tracking log and reviewed at the monthly QA meeting with any new recommendations implemented.</p>	

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	<p>related osteoporosis and enlarged prostate with lower urinary tract symptoms.</p> <p>The Medicare 5 day Minimum Data Set (MDS) assessment for Resident #48, dated 6/27/15, indicated the resident was occasionally incontinent of his bowel and bladder.</p> <p>The Significant change MDS assessment for Resident #48 dated, 8/18/15, indicated the resident was always incontinent of bowel and bladder.</p> <p>The careplan for Resident #48 indicated the resident had skin risk potential for skin breakdown related to a history chronic renal disease, chronic heart disease, osteoporosis, dry skin and a new GT placement (1/5/15). The interventions included, but were not limited to, (12/5/14) assist to toilet and or check and change at least every 2 hours and (6/20/15) toilet the resident in the morning, before meals, bed time and as needed at night.</p> <p>The "nursing supp/combo for bladder and bowel assessment" for Resident #48, dated 6/20/15, the instructions for the assessment were as followed: A.) "voiding and bowel pattern is to be initiated within 48 hours of new admissions on all incontinent residents</p>		The facility will be in compliance by October 16, 2015	

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	<p>and when a decline in incontinence is noted to determine if any natural patterns can be determined." "Do not need to redo the void/bowel pattern unless there is decline in continence." B) "complete the following assessment after the void/bowel pattern is completed by at least day 5 of the new admission and/or determination of decline in continence." The assessment indicated the resident was occasionally incontinent of his bowel and bladder. The resident was mentally aware of his need to use the restroom. The resident request assistance to use the urinal and the bedside commode. The conclusion was there was a voiding pattern detected, the resident was mentally and physically aware of the need to void and was able to use the toilet or other device, the resident was mentally and physically able to resist voiding for attempting a bladder retraining program. The resident had a toileting program currently being used to manage the resident's urinary and bowel continence.</p> <p>Interview with CNA #1 and CNA #2 on 9/16/15 at 1:51 p.m., indicated Resident #48 had been independent with his toileting needs and was now incontinent. CNA #2 indicated the resident use to walk to the bathroom with a walker and used a urinal. CNA #2 indicated the resident had pneumonia several months</p>			

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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356
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F 0312 SS=D Bldg. 00	<p>ago had declined a lot since returning from the hospital. CNA #1 and CNA #2 provided incontinence care for the resident.</p> <p>Interview with the Director of Nursing (DON) on 9/17/15 at 9:55 a.m., indicated the MDS coordinator would have the nurse on the floor do the significant change bowel and bladder assessment.</p> <p>Interview with the MDS coordinator on 9/17/15 at 10:11 a.m., indicated she usually did the change in bowel and bladder assessment. The MDS coordinator indicated Resident #48 should have had a bowel and bladder done with the significant change MDS and the assessment was not completed. The MDS coordinator indicated the last bowel and bladder assessment and three day voiding pattern was completed in June 2015.</p> <p>3.1-37(a)</p> <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.</p>	F 0312		10/16/2015

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	<p>Based on observation, interview, and record review, the facility failed to ensure a dependant resident had assistance with oral care for 1 of 3 residents who met the criteria for oral health status. (Resident #43)</p> <p>Findings include:</p> <p>During an interview, on 9/15/15 at 11:44 a.m., Resident #43 indicated he had problems with his teeth because he is missing some teeth and didn't know when the last time his teeth were brushed. An observation of his mouth indicated a thick white buildup of debris between his teeth and on his gums. Resident #43 indicated staff hasn't said anything about this to him.</p> <p>Resident #43's record was reviewed on 9/16/15 at 10:08 a.m., and indicated an original admission date of 2/22/14 and a readmission date of 9/8/15. Physician's readmission orders, dated 9/8/15, indicated Resident #43 had diagnoses that included, but were not limited to, dementia with behavior disturbance, coronary artery disease, high blood pressure, anemia, and pacemaker.</p> <p>The readmission orders indicated an order for "may be seen by dentist"</p>		<p>F312 – ADL Care Provided For Dependent Residents</p> <p>The facility respectfully submits the following plan of correction as proposed remedies to the cited concerns, of which all residents have the potential to be affected.</p> <p>It is the policy of Miller's Merry Manor that all residents have oral care included in their daily routine twice a day and as needed. All nursing staff will be in-serviced Oct 7, 2015 on the following policies: Oral care (Attachment J), Morning Care (Attachment K) and Bed Time Care (Attachment L). A review of oral care</p>	

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	<p>A quarterly Minimum Data Set assessment, dated 7/17/15, indicated Resident #43 was moderately impaired in cognitive skills for daily decision making and required extensive assistance of one for personal hygiene that included brushing his teeth.</p> <p>A nursing admission/return assessment, dated 9/8/15, indicated Resident #43 had his own teeth.</p> <p>A care plan, dated 8/20/15, indicated: "Potential for oral/dental problems related to: need for assistance with ADL's (activities of daily living). Goal: Will have no oral/dental issues. Interventions/Tasks: Assess oral cavity upon admission and at least quarterly. Encourage oral care twice a day and assist as needed. Provide supplies for oral care. Refer to dentist/hygienist for evaluation/recommendations re: mouth care, teeth pulled, repair of carious teeth."</p> <p>On 9/16/2015 at 4:38 p.m., Resident #43 was observed in the TV lounge watching TV with other residents. He showed his teeth which were coated with white/yellow debris on the top and bottom teeth.</p> <p>On 9/17/2015 at 12:18 p.m., Resident #43 was observed in the dining room for</p>		<p>documentation in Point of Care will also be included. To monitor for reoccurrence of this deficient practice, the QA Tool Oral Care (Attachment M) will be completed by DON or designee 5 days a week for 2 weeks, weekly for 4 weeks, then monthly thereafter. Any concerns will be addressed immediately, recorded on a facility QA tracking log and reviewed at the monthly QA meeting with any new recommendations implemented.</p> <p>The facility will be in compliance by October 16, 2015</p>	

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	<p>the noon meal. When spoken to, Resident #43 smiled and white debris was observed in his upper teeth.</p> <p>On 9/18/2015 at 10:30 a.m., CNA #7 was observed in Resident #43's room shaving his face. Resident #43 smiled and debris was observed on his teeth especially in the areas between his teeth. A toothbrush and toothpaste was observed in his bedside stand and CNA #7 indicated she didn't know when his teeth were brushed, but thought it was in the morning when they got him up.</p> <p>A dental exam by a service provider had been done on 3/12/15 and indicated the oral cancer screening was negative, oral hygiene was poor, gingival tissue inflamed, debris level was moderate, and there was no bleeding. The exam did not indicate if a cleaning had been done.</p> <p>On 9/18/2015 at 12:51 p.m., the Director of Nursing (DoN) indicated the service provider did not do a cleaning, they just did an exam. The DoN also indicated dental care should be done with a.m., and p.m., care, it is standard care when he gets up and when he goes to bed.</p> <p>A policy and procedure for "Oral Care", with an effective date of 1/1/2009, was provided by the DoN on 9/18/15, at 2:50</p>			

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F 0323 SS=D Bldg. 00	<p>p.m. The policy indicated, but was not limited to, "1. Purpose: To cleanse the mouth for personal hygiene and to lessen the occurrence of mouth infections...."</p> <p>3.1-38(a)(3)(C)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to keep a resident's head of the bed elevated at an 30-40 degree angle while a continuous gastrostomy tube (G-tube) feeding (nutrition provided directly into the stomach) was being administered for 1 of 1 resident who met the criteria for decline in incontinence status and failed to transfer a resident safely with use of a mechanical lift for 1 of 3 residents who met the criteria for skin conditions non-pressure for 2 of 3 mechanical lift transfer observations (Resident #48 and Resident #61).</p> <p>Findings include:</p> <p>1.) Review of the electronic health record of Resident #48 on 9/16/15 at 10:11 a.m., indicated the resident's diagnoses</p>	F 0323	<p>F323 – Free of Accident Hazards/Supervision/Devices</p> <p>The facility respectfully submits the following plan of correction as proposed remedies to the cited concerns.</p> <p>The facility currently only has 1 resident that receives continuous G-tube feedings during</p>	10/16/2015

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	<p>included, but were not limited to, atrial fibrillation, hypertension, dementia with behaviors, hypothyroidism, kidney failure, age related osteoporosis, aspiration pneumonia and enlarged prostate with lower urinary tract symptoms.</p> <p>The plan of care for Resident #48, dated 1/7/15, indicated the resident required G-tube to assist in maintaining or improving nutritional and hydration status due to dysphasia (swallowing impairment). The intervention included, but were not limited to, elevate the head of the bed at all times.</p> <p>The plan of care for Resident #48, dated 8/21/15, indicated the resident had left lower infiltrates. The wife gives oral fluid despite knowing the risk of aspiration. The interventions included, but were not limited to, continue to educate the wife on risks of aspiration with oral fluids.</p> <p>The Significant change Minimum Data Set (MDS) assessment for Resident #48, dated, 8/18/15, indicated his nutritional approach was a feeding tube.</p> <p>The physician recapitulation for Resident #48, dated September 2015, indicated the resident was to have the head of the bed elevated every shift.</p>		<p>the night. This resident does have orders for head of bed to be elevated while receiving continuous feeding. There are other residents that require the use of a mechanical lift that have the potential to be affected.</p> <p>To correct this deficient practice all nursing staff will be in-serviced Oct 7, 2015 on the following policies: Enteral – Care of the Resident (Attachment N) and Mechanical Lift Transfers (Attachment O). The in-service will include a skills check off for staff to complete a return demonstration of the proper way to use the mechanical lift. To monitor for reoccurrence of this deficiency, the QA</p>	

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	<p>The physician telephone order for Resident #48, dated 9/8/15, indicated the resident was ordered a continuous feeding of (brand name of tube feeding) 1.2 set at 79 milliliters per hour.</p> <p>During observation on 9/16/15 at 12:15 p.m., CNA #1 and CNA #2 was providing incontinence care for Resident #48. CNA #1 lowered the resident's bed to a flat position. When queried if the resident's G-tube was running, CNA #1 indicated yes it was and the nurses "never turn it off" before care was being provided. CNA #1 elevated the resident's head of the bed back up to 30 degree angle and got the nurse. RN #3 came into the room and shut off the G-tube off.</p> <p>During interview with RN #3 on 9/16/15 at 2:30 p.m., the CNA's were suppose to get the nurse to shut off the G-tube before providing incontinence care. RN #3 indicated the CNA's usually did.</p> <p>During interview with RN #3 on 9/16/15 at 3:15 p.m., indicated CNA #1 reported that she had laid Resident #48 flat in bed with the G-tube running. RN #3 indicated she had done a lung assessment on Resident #48 and his upper lobes were clear and his lower lobes were diminished. RN #3 indicated the</p>		<p>Tool Enteral Care &amp; Mechanical Lift (Attachment P) will be completed by DON or designee 5 days a week for 2 weeks, weekly for 4 weeks, then monthly thereafter. Any concerns will be addressed immediately, recorded on a facility QA tracking log and reviewed at the monthly QA meeting with any new recommendations implemented.</p> <p>The facility will be in compliance by October 16, 2015</p>	

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	<p>resident's lower lobes being diminished was not new for this resident as they had been diminished.</p> <p>Interview with the Director of Nursing (DON) on 9/17/15 at 9:55 a.m., indicated the CNA's were suppose to get the nurse to shut off tube feedings before laying the resident flat. The DON indicated the CNA assignment sheet and shift report were how the CNA's were informed if a resident was required to have the head of the bed elevated at all times. Observation at this time with DON of the CNA assignment sheet Resident #48 did not have instructions to keep the head of the bed elevated. The DON indicated the unit manager was responsible to keep the assignment sheets updated and he would update the assignment sheet for the safety precautions for Resident #48. The DON indicated the resident's wife gave him fluids and the facility had educated her not to do this and this could be a contributing factor for the resident's chronic aspiration pneumonia.</p> <p>Interview with the primary care physician on 9/18/15 at 12:15 p.m., indicated his medical opinion of why Resident #48 had an ongoing diagnosis of aspiration pneumonia was the resident had some salivation aspiration and the resident's wife continued to give the resident fluids.</p>			

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	<p>The primary care physician indicated the facility did report to him the staff had laid the resident flat with G-tube running and that staff should be keeping the resident's head of the bed elevated when the feeding was running.</p> <p>The "enteral care of the resident" policy provided by the Administrator on 9/17/15 at 1:35 p.m., indicated "keep the head of bed elevated 30-45 degrees to prevent gastric reflux and possible aspiration at all times with continuous feeding".</p> <p>2. Resident #61's record was reviewed on 9/17/15 at 9:30 a.m. Her diagnoses on her September 2015 physician's recapitulation orders indicated but were not limited to, debility and muscle weakness.</p> <p>Resident #61's admission Minimum Data Set (MDS) assessment dated 9/4/15, indicated she required total dependence of 2 plus persons for transfer, she did not walk, and she had impairment in both of her lower extremities.</p> <p>The CNA Assignment Sheet provided by the DON on 9/17/15 at 10:00 a.m., indicated Resident #61 would be transferred by staff with the use of a mechanical lift and she utilized a wheelchair for mobility.</p>			

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	<p>On 9/16/15 at 1:31 p.m., Resident #61 was observed being transferred from her wheelchair to her bed with assistance from CNA #1 and CNA #2 and the use of a mechanical lift. Resident #61 was lifted from her wheelchair with the mechanical lift legs in the opened position. The wheelchair was moved away from the mechanical lift. The mechanical lift was turned toward the bed and then the mechanical lift legs were placed in the closed position. The mechanical lift legs were moved under the bed and then Resident #61 was lowered to her bed mattress. While Resident #61 was being lowered to her bed mattress the right mechanical lift leg lifted completely off of the floor. At that time CNA #2 indicated because Resident #61's trapeze foot bar extended so far under the bed the staff operating the mechanical lift sling had to push the resident while still in the air toward the head of the bed to position her. CNA #2 indicated when the mechanical lift sling was pushed toward the head of the bed it caused the mechanical lift leg to lift off of the floor. CNA #1 and CNA #2 indicated the mechanical lift legs were to be in the closed position under the bed.</p> <p>On 9/17/15 at 10:24 a.m., CNA #2 indicated after the mechanical lift procedure on 9/16/15 at 1:31 p.m., he had</p>			
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	<p>reported to the Assistant Director of Nursing and LPN #5 the mechanical lift leg had lifted off of the floor during the transfer.</p> <p>On 9/17/15 at 10:41 a.m., Resident #61 was observed being transferred from her bed to her wheelchair with assistance from CNA #7 and LPN #5 and the use of an (brand name of mechanical lift). The mechanical lift legs were placed under the bed in the closed position. Resident #61 was lifted from her bed mattress and the mechanical lift legs began being pulled out from underneath the bed. It was requested the mechanical lift legs be placed back under the bed to position Resident #61 over her bed mattress. At that time CNA #7 indicated she was going to back away from the bed some and then open the mechanical lift legs and place them around Resident #61's wheelchair. CNA #7 indicated she normally removed the mechanical lift legs from underneath the bed some before placing them in the opened position. CNA #7 then indicated the mechanical lift legs should always be in the opened position underneath a bed, when lifting a resident and when transferring a resident. LPN #5 indicated the mechanical lift legs should be in the closed position underneath the bed and in the opened position when a resident was</p>			

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	<p>placed in their wheelchair.</p> <p>On 9/17/15 at 11:05 a.m., LPN # 9 indicated she had assumed Inservice Director duties on 8/1/15. She indicated she had been made aware the mechanical lift leg had lifted off of the floor during an observation on 9/16/15.</p> <p>The "Manual/electric portable patient lift owner's installation and operating instructions" was provided by the Administrator on 9/16/15 at 2:18 p.m. A " Warning" box on page 9 of the manual indicated the following: "Only operate this lift with the legs in maximum open position and locked in place. The base legs must be locked in the open position at all times for stability and patient safety when lifting and transferring a patient."</p> <p>3.1-45(a)(2)</p>			