

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit also included the Investigation of Complaints IN00142108, IN00142318, IN00142323 and IN00142333.</p> <p>Complaint IN00142108- Substantiated. Federal/State deficiency related to the allegations is cited at F-323 and F282.</p> <p>Complaint IN00142318- Unsubstantiated, Due to lack of evidence.</p> <p>Complaint IN00142323- Substantiated. Federal/State deficiency related to the allegations is cited at F282, F323, and F-465.</p> <p>Complaint IN00142333- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 13, 14, 15, 16, 17, 22, & 23, 2014.</p> <p>Facility number: 000018 Provider number: 155053 AIM number: 100273930</p> <p>Survey team:</p>	F000000		

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>Angel Tomlinson, RN, TC Barbara Gray, RN Leslie Parrett, RN Janelyn Kulik, RN [January 13, & 14, 2014] Penny Marlatt, RN [January 22, & 23, 2014]</p> <p>Census bed type: SNF: 8 SNF/NF: 51 Residential: 21 Total: 80</p> <p>Census payor type: Medicare: 8 Medicaid: 53 Other: 19 Total: 80</p> <p>Residential sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 29, 2014, by Janelyn Kulik, RN.</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow a physician's ordered diet and use a gait belt during a transfer as care planned for 2 of 19 residents reviewed for physician's orders and care plans. (Resident #29 and Resident #H)</p> <p>Findings include:</p> <p>1. On 1/15/14 at 12:01 P.M., Resident #29 was observed seated in her recliner in her bedroom. Her lunch tray was delivered to her room by staff and her meal items included a whole chicken breast. Resident #29 indicated she fed herself and "for the most part" did not have any trouble chewing or swallowing. She indicated she wore a full set of dentures and sometimes dietary ground her meat up if she had</p>	F000282	<p>Resident # 29 Was evaluated by Speech Therapy (Attachment #1) and determined that resident does not have any swallowing impairments but may continue with ground meat diet per resident's preference for ease of chewing and swallowing. Resident # 29 has been served the correct diet each meal since. This is checked by the dietary department and then again by nursing when they deliver the tray to ensure diet is served per meal ticket/diet order. Resident #29 did not have any negative outcomes from this practice. All residents have the potential to be affected by this practice. All trays were checked on 3 different meal services and no other inaccuracies were found. (Attachment #2) Dietary Manager re-educated all staff members on resident's diet and reviewing meal ticket before serving. (Attachment # 3) Dietary Manager re-educated all staff working on the serving</p>	02/11/2014

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	<p>difficulty chewing. She indicated she had no problems with her dentures.</p> <p>Resident #29's record was reviewed on 1/15/14 at 12:39 P.M. Diagnoses included but were not limited to, atrial fibrillation, hypertension, peripheral vascular disease, diabetes, and End Stage Renal disease.</p> <p>A fax sent to the physician on 12/23/13 at 11:56 A.M., by RN#3 indicated the following information: Resident #29 requested a ground meat diet because she had been having trouble swallowing her meat at meals and choking on it. The physician responded yes to the ground meat diet.</p> <p>A Progress Note for Resident #29 dated 12/23/13 at 13:46 P.M., indicated an order was received to change her diet to ground meats. Resident #29 and dietary were aware.</p> <p>A Nutrition Care Plan for Resident #29 initiated 12/23/13, indicated the following: Resident #29 was at nutritional risk. Her Care Plan interventions included but were not limited to, a carbohydrate controlled</p>		<p>line for serving correct diet by reviewing meal ticket and visual observation. (Attachment #3) If any inaccuracies in diet served they will be corrected immediately Staff re-educated on 2-7-14 (Attachment #4) on reviewing the resident meal ticket and completing a visual observation to ensure the diet is prepared and served as ordered. A minimum of 10 resident meals will be observed for accuracy in diet to ensure the residents are provided the correct diet including consistency as ordered. Corrective action will be QA monitored daily x 1 week, weekly x 4 weeks and monthly x 6 months the Meal Tray Audit Tool (Attachment # 5) to ensure the residents are provided the correct diet including consistency as ordered. The results will be reviewed by the QA committee and any recommendations will be implemented. Date of completion: 2/11/14 Resident #H experienced no negative outcomes as evidenced by a safe transfer during observation. Resident # H has since been transferred correctly with a 1 person per plan of care. No other residents were affected by this deficient practice. No observation of incorrect number of staff members or lack of use of gait belt with transfers occurred. No reports of falls or injury related to incorrect number of assist or lack of gait belt use. All care plans were checked for</p>				

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	<p>diet with ground meat.</p> <p>Resident #29's January 2014, recapitulation physician's order indicated Resident #29 would be served a carbohydrate controlled diet with ground meat.</p> <p>On 1/15/14 at 1:06 P.M., the Dietary Manager indicated Resident #29 should have received ground meat on her lunch tray. She indicated it was an oversight "today." She indicated she had spoken with Cook #4 and she had remembered she had served Resident #29 a whole chicken breast and should have served her ground chicken breast. The Dietary Manager indicated she was going to do an in-service.</p> <p>2. During an observation on 1-16-14 at 9:25 a.m. CNA #1 transferred Resident #H from the wheelchair to the bed. CNA #1 held Resident #H under the right arm and pulled the resident up to a standing position, assisted the resident to turn around</p>		<p>correct interventions related to transfers and gait belt use. (Attach #6). These were all put on CNA assignment sheets to reflect the care plan. C.N.A.'s were instructed to check their assignment sheets each shift they work for correct interventions. (Attachment # 13)Nursing staff re-educated on 2-7-14 (Attach #4) on Policy and Procedure of Gait Belt use and Procedure(Attachment #7) and on referring to the CNA assignment sheets for the correct number of staff needed for transfer. A minimum of 10 residents will be observed during transfers to ensure correct number of staff and gait belt used as per the resident's plan of care. Corrective action will be QA monitored daily x 1 week, weekly x 4 weeks, then monthly x 6 months using the Gait Belt Transfer Tool (Attachment # 8) to ensure the proper number of staff and gait belt is used per the resident's plan of care during transfers. The results will be reviewed by the QA committee and any recommendations will be implemented. Date of Completion: 2/11/14</p>				

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	<p>and sit on the bed. When queried if a gait belt was suppose to be use for Resident #H during transfers, CNA #1 indicated no the resident used a gait belt for ambulation but not for transfers.</p> <p>Review of the record of Resident #H on 1-16-14 at 12:20 p.m. indicated the resident's diagnoses included, but were not limited to, senile dementia with delusional features, diabetes, anxiety, depression and osteoarthritis.</p> <p>The fall risk assessment dated 12-6-13 for Resident #H indicated the following: had a history of falls in the past 30 days, had confusion/forgetfulness, weakness, poor vision, used assistive devices, had an unsteady gait with or without assistance, slow shuffling gait, history of pacing without regard for need to rest, impaired balance with transfers with or without assistance, required staff for physical support to transfer, use of narcotics or psychoactive medication and the use of a diuretic.</p> <p>The Minimum Data Set (MDS) Quarterly Assessment for Resident #H dated 12-11-13 indicated the resident was extensive assistance of</p>				

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	<p>two people to transfer.</p> <p>The fall risk care plan for Resident #H with an initiated date of 3-17-09 indicated the resident had fall risk factors of history of falls, confusion/dementia, unsteady gait, use of antipsychotic medication, diuretic medication and poor vision. The interventions included, but were not limited to, gait belt used with all transfers.</p> <p>Interview with Unit Manager #1 on 1-22-14 at 10:40 a.m. indicated the staff were to use a gait belt with all of Resident #H's transfers.</p> <p>The gait belt policy provided by the Assistant Director Of Nursing (ADON) on 1-23-14 at 1:45 p.m. indicated the purpose was to insure safety in transfer and ambulation. The gait was to provide a point of contact and increased support from the staff and prevent injuries to staff and residents who are unable to transfer or ambulate independently. The gait belt will be used as indicated on the individual's care plan.</p> <p>This Federal tag relates to compliant IN00142108 and IN00142323.</p>				

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F000323 SS=D	<p>3.1-35(g)(2)</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 transfer a resident using a gait belt and failed to clarify when the resident was to have two staff assistance during transfers for a resident with a history of falls and high risk for falls for 1 of 4 residents reviewed for falls of 6 residents who met the criteria for accidents (Resident #H).</p> <p>Finding include:</p> <p>1.) During an observation on 1-16-14 at 9:25 a.m. CNA #1 transferred Resident #H from the wheelchair to the bed. CNA #1 held Resident #H under the right arm and pulled the resident up to a standing position, assisted the resident to turn</p>	F000323	Resident #H experienced no negative outcomes as evidenced by a safe transfer during observation. Resident # H has since been transferred correctly with a 1 person per plan of care. No other residents were affected by this deficient practice. No observation of incorrect number of staff members or lack of use of gait belt with transfers occurred. No reports of falls or injury related to incorrect number of assist or lack of gait belt use. All care plans were checked for correct interventions related to transfers and gait belt use. (Attach #6). These were all put on CNA assignment sheets to reflect the care plan. C.N.A.'s were instructed to check their assignment sheets each shift they work for correct interventions. (Attachment # 13) Nursing staff re-educated on 2-7-14 (Attach #4) on Policy and Procedure of Gait Belt use and	02/11/2014	

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	<p>around and sit on the bed. When queried if a gait belt was suppose to be use for Resident #H during transfers, CNA #1 indicated no the resident used a gait belt for ambulation but not for transfers.</p> <p>Review of the record of Resident #H on 1-16-14 at 12:20 p.m. indicated the resident's diagnoses included, but were not limited to, senile dementia with delusional features, diabetes, anxiety, depression and osteoarthritis.</p> <p>The Occurrence Initial Assessment for Resident #H dated 12-5-13 indicated the staff were trying to stand the resident to transfer into the wheelchair. The resident collapsed and was noted to have an abrasion and bruising to her nose and bilateral knees, the resident's left hip was red and the resident complained of pain in her right hip.</p> <p>The emergency room record for Resident #H dated 12-5-13 indicated the resident had a fall at the nursing home due to loss of balance. The resident had pain to her face and right and left hip. The resident had abrasion to the bridge of her nose and swelling of the face. The resident had an x-ray of the right</p>		<p>Procedure(Attachment #7) and on referring to the CNA assignment sheets for the correct number of staff needed for transfer. A minimum of 10 residents will be observed during transfers to ensure correct number of staff and gait belt used as per the resident's plan of care. Corrective action will be QA monitored daily x 1 week, weekly x 4 weeks, then monthly x 6 months using the Gait Belt Transfer Tool (Attachment # 8) to ensure the proper number of staff and gait belt is used per the resident's plan of care during transfers. The results will be reviewed by the QA committee and any recommendations will be implemented. Date of Completion: 2/11/14</p>		

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	<p>femur and pelvis due to pain and both were negative for a fracture.</p> <p>The post occurrence assessment for Resident #H dated 12-6-13 indicated the resident had a fall on 12-5-13. The resident was being assisted with a transfer and the resident collapsed when she stood up and fell to the floor. The staff were unable to keep the resident upright. The resident had an abrasion and bruising to the nose, bruising to both knees and redness to the left hip. The root cause was the resident's knees buckled upon rising. The recommendations were ensure the resident was steady before rising and ensure the resident was stable before transfers.</p> <p>The fall risk assessment dated 12-6-13 for Resident #H indicated the following: had a history of falls in the past 30 days, had confusion/forgetfulness, weakness, poor vision, used assistive devices, had an unsteady gait with or without assistance, slow shuffling gait, history of pacing without regard for need to rest, impaired balance with transfers with or without assistance, required staff for physical support to transfer, use of narcotics or psychoactive medication and the</p>				

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	<p>use of a diuretic.</p> <p>The Minimum Data Set (MDS) Quarterly Assessment for Resident #H dated 12-11-13 indicated the resident was extensive assistance of two people to transfer.</p> <p>The fall risk care plan for Resident #H with an initiated date of 3-17-09 indicated the resident had fall risk factors of history of falls, confusion/dementia, unsteady gait, use of antipsychotic medication, diuretic medication and poor vision. The interventions included, but were not limited to, gait belt used with all transfers.</p> <p>Interview with the Director Of Nursing (DON) on 1-22-14 at 10:10 a.m. indicated Resident #H fell on 12-5-13 during a transfer. The DON indicated one staff was using a gait belt to transfer the resident from the bed to the wheelchair. The resident went to stand up from the bed and her knees buckled and she fell forward. The DON indicated the facility was unsure what the root cause of the fall was because the resident stood up and fell forward. The DON indicated intervention implemented was to ensure the resident was stable before rising and</p>						

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	<p>stable before all transfers.</p> <p>Interview with the MDS coordinator on 1-22-14 at 10:25 a.m. indicated the 12-11-13 MDS for Resident #H was marked correctly of extensive assistance of two people for transfers. The MDS coordinator indicated Resident #H could be transferred with the assistance of 1 or 2 people, it depended on how the resident was feeling. The CNA transferring her can decide if they need two people or go tell their nurse if they can not transfer her with one person. The MDS coordinator indicated the facility would not update the care plan to two people assist with transfers because the MDS indicated the resident was extensive assistance of two people. When queried how the facility staff would know the MDS had been coded for the resident to be transferred with extensive assistance of two people, the MDS coordinator indicated she would communicate it to the unit manager during morning meeting.</p> <p>Interview with Unit Manager #1 on 1-22-14 at 10:40 a.m. indicated Resident #H used two people to transfer at times. The Unit Manager indicated she was not informed that</p>				

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	<p>the resident's MDS assessment indicated the resident was extensive assistance of two people. Unit Manager #1 indicated the staff were to use a gait belt with all of Resident #H's transfers.</p> <p>The fall management policy provided by the DON on 1-17-14 at 10:40 a.m. indicated the purpose was to assess all residents for risk factors that may contribute to falling and to provide planned interventions identified by the team as appropriate for resident use in maintaining or returning to the highest level of physical, social, and psychosocial functioning as possible.</p> <p>The gait belt policy provided by the Assistant Director Of Nursing (ADON) on 1-23-14 at 1:45 p.m. indicated the purpose was to insure safety in transfer and ambulation. The gait was to provide a point of contact and increased support from the staff and prevent injuries to staff and residents who are unable to transfer or ambulate independently. The gait belt will be used as indicated on the individual's care plan.</p> <p>This federal tag relates to compliant IN00142108 and IN00142323.</p>				

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F000465 SS=D	<p>3.1-45(a)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review the facility failed to maintain a safe and sanitary environment by not repairing 3 loose metal drain cover plates and 2 Residents' bathrooms with dust hanging from the ceiling vents on the East unit for 1 of 2 units toured and the facility failed to keep resident rooms free of urine odor for 2 or 3 residents reviewed for urinary</p>	F000465	<p>Metal drains tightened, bathroom vents dusted, resident rooms deep cleaned, and resident bathroom floor ordered to replace cracked tile around toilet area. No other residents affected by the deficient practice. All drains tightened, vents cleaned, rooms checked for urine odor, and bathroom flooring checked for cracked tile. Housekeeping staff will begin using Housekeeping Checklist daily (Attachment #9) to ensure the vents are free of dust and no</p>	02/11/2014

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	<p>incontinence of 1 who met the criteria for urinary incontinence (Resident #J and Resident #H).</p> <p>Findings include:</p> <p>1. During initial tour on 1/13/14 at 11:45 a.m. loose a metal plate was observed on the floor in the middle of the East unit hallway between Rooms 23 and 24 on the south side of the hall and Rooms 25 and 26 on the north side of the hall.</p> <p>On 1/14/14 at 9:14 a.m. cracked floor tiles were observed from the toilet area to the wall across from the toilet, the ceiling vent had dust hanging from it and a metal plate by the toilet was loose in the bathroom of Room 61.</p> <p>During an observation on 1/14/14 at 9:25 a.m. the ceiling vent had dust hanging from it and a metal plate by the toilet was loose in the bathroom of Room 64.</p> <p>Interview with the Maintenance Supervisor on 1/22/14 at 12:05 p.m. indicated he saw the dusty vents and the loose metal drain plates and would take care of it right away.</p>		<p>urine odor is detected. Housekeeping staff will be in-serviced on Housekeeping Checklist to ensure the vents are free of dust and no urine odor is detected. Maintenance staff will begin using Metal Drain Plate Audit (Attachment #10) monthly to ensure all metal drain covers are not loose. Maintenance staff will use Room Inspections Check (Attachment #11) monthly to ensure floor tiles are not cracked. A minimum of 10 drains will be checked by Administrator or designee daily x 1 week, weekly x 1 month, and monthly x 6 months to ensure drains are not loose using QA tool titled, "Environmental Rounds" (Attachment #12) A minimum of 10 vents will be check checked by Administrator or designee daily x 1 week, weekly x 1 month, and monthly x 6 months to ensure vents are not dusty using QA tool titled, "Environmental Rounds" (Attachment #12) A minimum of 10 rooms will by checked by Administrator or designee daily x 1 week, weekly x 1 month, and monthly x 6 months to ensure room are free of urine odor using QA tool titled, "Environmental Rounds" (Attachment #12) A minimum of 10 bathroom floors will be check by Administrator or designee daily x 1 week, weekly x 1 month, and monthly x 6 months to ensure floors are free of cracked tiles using QA tool titled, "Environmental Rounds"</p>		

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	<p>2.) During an observation on 1-13-14 at 10:59 a.m. Resident #J was sitting in his room in his wheelchair and the room had a strong urine smell.</p> <p>During an observation on 1-14-14 at 11:20 a.m. Resident #J was laying in bed, his room smelled of strong urine and the urine smell could be detected in the hallway before entering the resident's room.</p> <p>During an observation on 1-15-14 at 1:20 p.m. Resident #J was laying in bed covered up, the resident's room had a strong urine smell. Unit Manager #2 checked Resident #J for incontinence of bladder. Unit Manager #2 agreed the resident's room had a strong urine smell. Unit Manager #2 indicated when the resident's room smelled of urine it</p>		<p>(Attachment #12) Corrective action will be QA monitored daily x 1 week, weekly x 4 weeks, then monthly x 6 months using the Environmental Rounds Audit Tool (Attachment #12) to ensure drains are not loose, vents are dust free, odors are not present and floors are free from cracks. The results will be reviewed by the QA committee and any recommendations will be implemented. Date of Completion: 2/11/14</p>		

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	<p>was usually his roommate's urinal that caused the smell. Observation at this time Resident #J's roommate's did have a urinal hanging at the end of his bed, the urinal was empty. Resident #J was checked for incontinence was found to be barely wet. Unit Manager #2 provided incontinence care. The resident's room continued to smell like urine after the care was provided.</p> <p>Review of the record of Resident #J on 1-16-14 at 11:05 a.m. indicated the resident's diagnoses included, but were not limited to, flaccid hemiplegia, anemia, congestive heart failure, sleep disturbance, kyphosis and constipation.</p> <p>The Minimum Data Set (MDS) Quarterly Assessment for Resident #J dated 10-23-13 indicated the resident was always incontinent of urine and BIMS (Brief Interview for Mental Status) was 7, severe impairment.</p> <p>3.) During an observation on 1-16-14 at 9:25 a.m. CNA #1 provided Resident #H with incontinent care, Resident #H's bedroom smelled of strong urine.</p>				

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	<p>CNA #1 indicated the Resident #H always smelled of strong urine.</p> <p>Review of the record of Resident #H on 1-16-14 at 12:20 p.m. indicated the resident's diagnoses included, but were not limited to, senile dementia with delusional features, diabetes, anxiety, depression and osteoarthritis.</p> <p>The Minimum Data Set (MDS) Quarterly Assessment for Resident #H dated 12-11-13 indicated the resident was frequently incontinent of urine and cognitive skills for daily decision making was severely impaired.</p> <p>Interview with Resident #H's family member on 1-17-14 at 10:25 a.m. indicated when they visited the resident her room often smelled like urine. The family member showed a four pack of air fresheners and indicated they had to put air fresheners in the resident's room because of the strong urine smell. The family member indicated the family did not want to visit the with resident with a strong urine smell in the room so they put the air fresheners out to help with the odors.</p>				

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