

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/15/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 7, 8, 9, 13, 14, & 15, 2012</p> <p>Facility number: 000174 Provider number: 155274 AIM number: 100274810</p> <p>Survey team: Terri Walters RN TC Carole McDaniel RN Martha Saull RN Dorothy Watts RN</p> <p>Census bed type: SNF: 2 SNF/NF: 49 Total: 51</p> <p>Census payor type: Medicare: 2 Medicaid: 34 Other: 15 Total: 51</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/19/12 by Suzanne Williams, RN</p>	F0000	Please accept this credible allegation of compliance to the findings of our anual ISDH survey completed on November 15, 2012. The facility respectfully requests to be considered for paper compliance revisit.	

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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F0167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure the state survey report was clearly labeled and easily accessible for all 6 days of the survey. This deficient practice had the potential to affect all 51 residents in the facility 11/7, 11/8, 11/9, 11/13, 11/14, 11/15/2012.</p> <p>Findings include:</p> <p>During initial tour of the facility on 11/7/12 at 9:00 A.M., a metal file holder was observed hanging on the wall at shoulder height for a 5' 2" person. The file holder was located on the wall just inside the main entrance. There were two binders in the holder. On the spine of each binder was a label, one label indicated the contents of the binder contained the State Department of Health annual report. The label was unable to be read from wheelchair</p>	F0167	<p>It is the practice of this facility to have survey results readily available to residents. The facility lowered the metal file holder on 11/15/2012 to be accessible at wheelchair height. The binder containing the results was also re-labeled in order to be read from wheelchair height. The facility will utilize the Quality Assurance Tool titled General Observations of the Facility (Attachment A) to monitor that the survey results remain readily available. This tool will be completed by the Administrator or designee monthly.</p>	12/15/2012	

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	<p>height and was not readily accessible from wheelchair height. The binder was observed in this location every day of the survey.</p> <p>On 11/15/12 at 10:15 A.M., the Administrator was made aware of the location/position of the state survey report on the wall. She was interviewed at this time and indicated the state survey was not clearly labeled and/or accessible to wheelchair height residents.</p> <p>3.1-3(b)(1)</p>			

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F0441	It is the practice of this facility	12/15/2012			

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	<p>ensure prevention of transmitted infection between residents during 1 of 1 observation of 1 of 1 resident in contact isolation precautions with the potential to impact the residents on 1 of 3 facility units. Resident #44 on the East unit</p> <p>Findings include:</p> <p>On 11/14/12 at 8:00 A.M., the room of Resident # 44 was observed to have a posting on the door which directed visitors to check with the nurse before entry and isolation supplies set up in the hallway outside the door.</p> <p>On 11/14/12 at 8:10 A.M., LPN #15 indicated, on interview, Resident #44 was in contact precautions and was being treated for a urinary tract infection with the contagious organism ESBL (Extended Spectrum Beta-Lactamase).</p> <p>On 11/14/12 at 9:05 A.M., the care of Resident #44 by CNA#14 and CNA#16 was observed. Both CNAs donned disposable plastic gowns and gloves outside from the isolation supply set up in the hall. They checked the resident for incontinence and determined the resident was soiled with both urine and BM. CNA#14 cleansed the resident of</p>		<p>to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection.</p> <p>CNAs #14 and #16 were re-educated on infection control policies and procedures on 11/14/2012. All resident residing in the facility have the potential to be affected by the deficient practice.</p> <p>The facility will provide education for all staff on infection control policies and procedures. Inservices will be held on 11/27/2012, 12/6/2012 and 12/10/2012. Staff members will attend at least one of the inservices. Infection control education will include the following topics: standard precautions, gowning and gloving procedures, and linen handling.</p> <p>Infection control practices will be monitored utilizing the</p>				

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	<p>excrement, applied barrier cream and a new brief and changed her gloves while CNA #16 supported the resident on her side.</p> <p>The CNAs then, together, began to position the resident to assist her out of bed.</p> <p>CNA#14 reached under her plastic gown (clean area) and unbuckled a (clean)gait belt, wearing her soiled gloves. She also removed her (clean) pager from under her gown with her soiled gloves and placed it on the resident's (soiled)bedside table surface. The CNAs together applied the gait belt to the resident to safely transfer the resident to a specialized chair.</p> <p>CNA#16 bagged soiled trash and linen appropriately and then removed her soiled gown and gloves. She washed her hands and then used her clean hands to handle and bag soiled washable incontinent pads from the bed, rendering her hands soiled. In the process of that activity, she touched the bag and her hands against her (clean) uniform.</p> <p>CNA #14 removed gown and gloves and washed her hands. She then used her (clean) hands to take the (soiled) gait belt and pager with her.</p>		Quality Assurance Tool titled Infection Control Review (Attachment B). The infection control nurse or designee will complete the tool weekly for 4 weeks and monthly thereafter.				

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	<p>Without any cleansing or sanitizing of the both items, they were returned to general use.</p> <p>On 11/15/12 at 9:30 A.M., the DON (Director of Nursing) was informed of the observation and he provided related facility Policies and Procedures, which were reviewed at that time. The undated Policy and Procedure for Transmission Preventive Measures section G included "... Items such as blood pressure cuffs, stethoscopes, and thermometers should remain in the room or be thoroughly disinfected prior to reuse..."</p> <p>3.1-18(j)</p>				

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F0458 SS=E	<p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on record review, observation and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple resident rooms and 100 sq ft in single occupancy rooms. This was evidenced in 14 of 43 resident rooms in the facility. Rooms 3, 5, 7, 9, 13, 17, 19, 21, 22, 23, 24, 25, 10, 16.</p> <p>Findings include:</p> <p>Facility documentation of room size certification, dated 9/28/11, and provided by the Administrator on 11/14/12 at 1:15 P.M., indicated the following room sizes of observed rooms:</p> <p>*1. Room #3 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*2. Room #5 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*3. Room #7 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*4. Room #9 2 beds 154.65 sq ft</p>	F0458	The facility has requested a waiver for the rooms cited in the survey. The facility does not feel that the size of the rooms cited has any adverse affect on the residents in those rooms. CMS has granted the waiver in years past.	12/15/2012	

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	<p>SNF/NF 77.32 sq ft per resident</p> <p>*5. Room #13 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*6. Room #17 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*7. Room #19 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*8. Room #21 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*9. Room #22 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*10. Room #23 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*11. Room #24 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>*12. Room #25 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident</p> <p>These room sizes were verified by the Administrator on 11/15/12 at 8:45 A.M., as well as the room sizes of an additional two single occupancy rooms observed which were less than 100 sq ft as follows:</p> <p>*13. Room #10 1 bed 90.52 sq ft per resident</p>			

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	*14. Room #16 1 bed 90.52 sq ft per resident 3.1-19(l)(2)			
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