

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/19/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00179470 and IN00179997.</p> <p>Complaint IN00179470- Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F323.</p> <p>Complaint IN00179997- Substantiated. Federal/State deficiency related to the allegations is cited at F314.</p> <p>Survey dates: August 18 & 19, 2015</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Census bed type: SNF: 12 SNF/NF: 67 Total: 79</p> <p>Census payor type: Medicare: 15 Medicaid: 56 Other: 8 Total: 79</p> <p>Sample: 5</p>	F 0000		
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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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F 0314 SS=D Bldg. 00	<p>These deficiencies reflect State findings in accordance with 410 IAC 16.1-3.1.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure interventions to prevent skin breakdown were provided related to pressure reduction chair cushions not in place for 1 of 3 residents reviewed for pressure ulcer prevention in a sample of 5. (Resident #C)</p> <p>Finding includes:</p> <p>On 8/18/15 at 9:45 a.m., Resident #C was observed in a wheel chair in her room. There was a blue Hoyer (a mechanical left device) lift pad under the resident. CNA's #1 and #2 used the</p>	F 0314	<p>F-Tag 314 Treatment/Services to Prevent Pressure Sores: It is the policy of Miller's Merry Manor, Hobart that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care related to pain management, treatments, and assessments. Resident # C: The cushion was replaced in the wheelchair.</p> <p><i>All residents are at risk to be affected by the deficient practice.</i></p> <p>An audit was completed on all residents for pressure reducing devices to chair. The care plan</p>	09/04/2015

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	<p>Hoyer lift device to transfer the resident from the wheel chair into her bed. There was no cushion on the seat of the resident's wheelchair.</p> <p>On 8/18/15 at 1:15 p.m., Resident #C was observed in a wheel chair in her room.</p> <p>There was a blue Hoyer lift pad under the resident. CNA's #1 and #2 used the Hoyer lift device to transfer the resident from the wheel chair into her bed. There was no cushion on the seat of the resident's wheelchair.</p> <p>The record for Resident #C was reviewed on 8/18/15 at 11:05 a.m. The resident's diagnoses included, but were not limited to, anemia, high blood pressure, and Alzheimer's disease.</p> <p>Review of the 5/26/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of two staff members for bed mobility and was totally dependent on staff for personal hygiene, bathing, and dressing. The assessment also indicated the resident was always incontinent of bowel and</p>		<p>and CNA pocket sheets were updated as appropriate.</p> <p>All licensed & non-licensed nursing staff was in-serviced on 08/21/2015 to review the facility policy on Skin Management Program.</p> <p>The Wound Nurse or other designee will be responsible to make rounds using (Attachment A) on all shifts to monitor for continued compliance for residents with pressure reducing devices daily x1 week, then 3x weekly x 4 weeks, then weekly x4 weeks, and monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected upon discovery and documented on facility QA tracking log. QA tracking logs are reviewed monthly during the facility QA meeting.</p>		

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	<p>bladder. The MDS assessment also indicated the resident was at risk for the development of pressure ulcers and had pressure reducing devices to the chair and bed.</p> <p>A Braden Scale for prediction for pressure ulcers, completed on 3/25/15, indicated the resident's score was (14). A score of (14) indicated the resident was at moderate risk for the development of pressure ulcers.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 2/10/15 indicated the resident had the potential for skin breakdown due to limited mobility and a diagnosis of diabetes mellitus. The Care Plan goal was for preventative measures to prevent skin breakdown to be provided. Care Plan interventions included, but were not limited to, provide pressure reducing devices to the resident's chair and bed.</p> <p>When interviewed on 8/18/15 at 3:35 p.m., the Director of Nursing indicated the resident did not have a pressure reducing cushion in place as per her plan of care.</p> <p>This Federal tag relates to Complaints IN00179470 and IN00179997.</p>			

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F 0323 SS=D Bldg. 00	<p>3.1-40(a)(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, record review, and interview, the facility failed to provide adequate supervision related to fall and safety interventions not in place for 2 of 3 residents reviewed for falls in a sample of 5. (Residents #D & #G)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 8/18/15 at 8:32 a.m., Resident #D was observed sitting in a wheel chair in his room. The was one auto-lock bar (a bar that stops the wheels when pressure on the seat changes) on the wheel chair. This bar was on the right rear wheel of the wheel chair. There were metal anti tipper bars on both the right and left rear wheels. The end of the bar on the left was turned with the end of bar facing up. The end of this bar had a small roller to stop the wheel chair from tipping when the top of the bar</p>	F 0323	<p>F-Tag 323 Free of Accidents Hazards/Supervision/Devices:It is the policy of Miller's Merry Manor, Hobart to ensure that each resident receives and the facility provides 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>Resident D: The auto lock breaks and anti-tippers to the wheelchair were repaired immediately by the Maintenance Director.</p> <p>Resident G: Dycem was replaced in the wheelchair immediately.</p>	09/04/2015	

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	<p>touched the floor. The end of the bar on the right side was facing the floor with the tip with the small roller close to the floor to prevent the chair from tipping over.</p> <p>On 8/18/15 at 9:14 a.m., the resident was observed in his wheel chair at doorway. The anti-tipper and auto lock bars remained in the same position as observed above. CNA #1 and CNA #2 entered the room and transferred the resident into his bed.</p> <p>On 8/18/15 at 1:20 p.m., the resident was observed in his wheel chair at a table in the Main Dining Room. The anti-tipper and auto lock bars remained in the same position as observed above.</p> <p>On 8/18/15 at 3:35 p.m., the Maintenance Director entered the resident's room to check the wheel chair. The Maintenance Director indicated the left anti- tipper was positioned incorrectly and the end should have been facing the floor. The Maintenance Director checked the auto lock brake on the right rear wheel. The Maintenance Director indicated the auto lock currently on the wheel chair was not working properly.</p> <p>The record for Resident #D was reviewed on 8/18/15 at 11:30 a.m. The resident's</p>		<p><i>All residents are at risk to be affected by the deficient practice.</i></p> <p>An audit was completed on all residents with auto lock breaks and anti-tippers to ensure proper function.</p> <p>An audit was completed on all residents Fall Care plans to ensure accuracy of interventions in place. CNA pocket sheets were updated as appropriate.</p> <p>All licensed staff and non-licensed staff was in-serviced on 08-21-2015 according to the facility policy on Fall Interventions/Protocol.</p> <p>The corrective action will be monitored utilizing the QA tool (Attachment B). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.</p>	

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	<p>diagnoses included, but were not limited to, senile dementia, congestive heart failure, and hemiplegia (paralysis on one side of the body).</p> <p>Review of the 5/27/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) for bed mobility, eating, and dressing. The assessment also indicated the resident was dependent on staff for transfers and personal hygiene. The assessment also indicated the resident had one fall in the last month prior to admission or reentry to the facility.</p> <p>The 5/20/15 Fall Risk Assessment indicated the resident's score was (12). A score of (12) indicated the resident was at high risk for falls. The assessment also indicated the resident had two or more falls in the last 30 thirty days.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 4/15/2008 indicated the resident was at risk for falls based on his Fall Risk</p>				

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	<p>assessment, the use of a Hoyer lift (a mechanical device to lift and transfer residents), poor positioning in the wheelchair, and a history of falls. The target goal date on the Care Plan was 9/24/15. Care plan interventions included, but were not limited to, auto-lock brakes on the wheelchair and Hoyer lift for transfers.</p> <p>A Nursing- Occurrence Initial Assessment form was completed on 7/3/15 at 4:45 p.m. The form indicated the resident was being transferred in the Hoyer lift by two CNA's. The resident was leaning to far on one side so the CNA's lowered him to the floor. No injuries were noted.</p> <p>A Nursing- Occurrence Initial Assessment form was completed on 7/24/15 at 8:00 p.m. The form indicated the resident had a fall in his room. The Nurse was called to the resident's room and observed the resident lying on the floor on his right side at the foot of his wheel chair.</p> <p>When interviewed on 8/18/15 at 3:35 p.m., the Director of Nursing indicated the anti tippers and auto locks breaks were to be in place for fall prevention.</p>			

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	<p>2. On 8/18/15 at 2:30 p.m., Resident #G was observed sitting in a wheel chair in her room. CNA #3 and CNA #4 transferred the resident to a standing position while the resident held onto her cane. There was no Dycem (a thin pad that sticks on the seat of the chair to prevent sliding) on the chair.</p> <p>The record for Resident #G was reviewed on 8/18/15 at 12:26 p.m. The resident's diagnoses included, but were not limited to, hemiplegia, high blood pressure, iron deficiency anemia, and accidental fall.</p> <p>Review of the 7/30/15 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assist of two staff members for bed mobility and transfers. The assessment also indicated the resident had limitations in range of motion in her upper and lower extremities on one side. The assessment also indicated the resident had one fall since admission/entry or reentry, or prior assessment.</p> <p>A Fall Risk Assessment completed on 5/1/15 indicated the resident's score was (14). A score of (14) indicated the resident was at moderate risk for falls.</p> <p>A Care Plan initiated on 4/18/13 indicated the resident was at risk for falls</p>			

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	<p>related to decreased mobility, assistive devices, and stoke. The Care Plan was last reviewed 8/2015 Care Plan interventions included, but were not limited to, Dycem in place to the wheel chair.</p> <p>A 6/25/15 Nursing- Occurrence Initial Assessment form indicated the resident fell in her room at 6:30 a.m. The resident denied any pain and no injuries were noted.</p> <p>When interviewed on 8/18/15 at 3:40 p.m., the Director of Nursing indicated the Dycem should have been in place .</p> <p>This Federal tag relates to Complaint IN00179470.</p> <p>3.1-45(a)(2)</p>			